January, 1958

Canadian Hospital

- *Teamwork in action*
- *The Red Cross in Vienna*
- *Accreditation worth the effort*
- *Ontario hospital insurance program*
- *Can statistics forecast health needs?*

Canadian Hospital Association

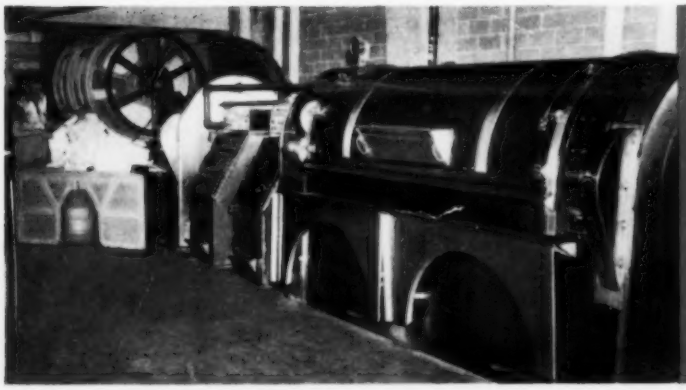
Oshawa General Hospital expands laundry facilities with less floor space, fewer operators

Caught in a typical squeeze between too much work and too little capacity, Oshawa General Hospital, Oshawa, Ontario, called in The Canadian Laundry Machinery Co.

Canadian engineers made a complete survey of the hospital's laundry needs, furnished detailed floor plans and equipment recommendations for complete modernization of the laundry facilities.

The results: Using less floor space and fewer operators than before, modern, high-production Canadian equipment more than doubled the laundry's previous capacity. Additional benefits were savings in supplies and water, improved quality of work and faster return of linens to service.

Whether building, expanding or remodeling, you too can benefit by Canadian's expert planning service and labor-saving automatic laundry equipment. For complete information, call or write.



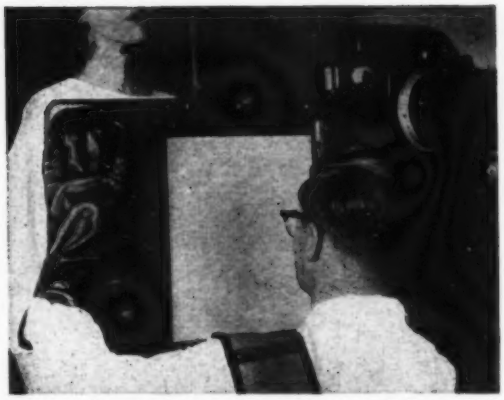
Cascade Unloading Washers with automatic controls are key to modernization of Oshawa General Hospital's laundry. Entire wash cycle is automatically controlled—without operator attention. Push-button unloading completes labor-saving operation.

Linens are beautifully ironed on 3-Roll Super-Sylon Flatwork Ironer, and automatically folded directly from ironer by Trumatic Folder. Automatic equipment maintains high-production schedule throughout every department of Oshawa Hospital's laundry.

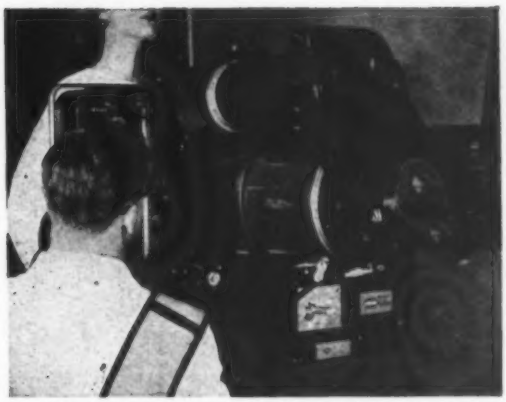
Canadian

The Canadian Laundry Machinery Company, Ltd.
47-93 Sterling Road Toronto 3, Ontario

WESTERN REPRESENTATIVES—Stanley Brock Limited, Winnipeg, Calgary, Edmonton, Vancouver



you can fluoroscope conventionally on a full size 14" X 14" screen for general exploration (for example, observing the entire esophagus while the patient swallows, or visualizing the whole colon or lung field).



you can instantly intensify the image of any local area (up to 5" diameter) by simply pushing the screen back and sliding the amplifying element over. Or do cinefluorography at will with the permanently-mounted camera (optional) seen here.

a single integrated system offering

- conventional fluoroscopy on a full-size screen
- intensified-image local fluoroscopy
- spotfilm radiography on 8" x 10" films
- spotradiography under fluoroscopic control

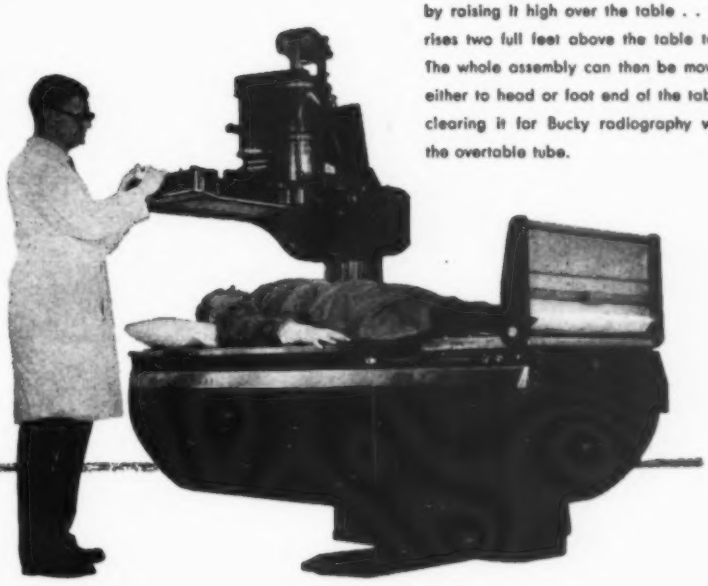
PICKER *amplifilmer*

you can employ any of these technics at any time because everything you need lies permanently within easy reach on the fluoroscopic deck.

Or you can shift from *any one to any other at any time* without attaching or detaching anything. The compact stage (aided by a power-assist system that imparts the reassuring "feel" you're used to) travels up, down, across the table with as little effort as it takes to move an ordinary spotfilm device.

Your local Picker man has a 10-minute "movie" on the Amplifilmer. Let him show it to you.

you can instantly park the Amplifilmer by raising it high over the table . . . it rises two full feet above the table top. The whole assembly can then be moved either to head or foot end of the table, clearing it for Bucky radiography with the overtable tube.



Picker x-ray

PICKER X-RAY ENGINEERING LIMITED
1074 Laurier Ave. W., Montreal, P.Q.

The Canadian Hospital Association is the federation of hospital associations in Canada and the Canadian Medical Association in co-operation with the federal and provincial governments and voluntary non-profit organizations in the health field.

Canadian Hospital

THE JOURNAL OF THE CANADIAN HOSPITAL ASSOCIATION

Editorial and Secretarial Offices: 280 Bloor St. West, Toronto 5, Ont.

Contents

January, 1958, Volume 35, No. 1.

(For Subscription Rates see page 84)

Business Manager: Charles A. Edwards
Advertising Manager: Thomas L. Wells
Advertising Offices: 57 Bloor St. West, Toronto 5, Ont.

...new 2 lb. and 4 lb. jars of Kraft Soup Base bring you portion control at its best!

Your soup making operation doesn't *have* to be a matter of by-guess-and-by-golly! Today your kitchen can have a reputation for good soup *every* day—and at a very exact cost. The answer to the problem is the Kraft Soup Base.

These easy-to-use jars of quality soup-base are proving economical for almost every type of kitchen. Specifically, they have four advantages that *you are invited to test* in your own kitchen, advantages you can prove for *yourself.*

★ **They're delicious:** true to Kraft's reputation for making good food—and their flavor doesn't vary from day to day.

★ **They're multi-use:** in addition to being the ideal soup-base. Add them to gravies, stews, meat-loaves, or as an enrichment for your own soup stocks.

★ **They're convenient:** because they're small enough to be easily handled and put away. Yet a 4 lb. jar is the equal of several *cases* of tinned soup.

★ **They're cheaper:** study the cost-chart here and you can estimate the savings for your own kitchen. With these "portion-controlled" jars you can measure your costs to the cent!

COST PER PORTION CHART

PRODUCT	PACK	ADD	SIZE PORTION	NO. OF SERVINGS	COST PER PORTION
CHICKEN BASE	1-lb. Jar	5-gals. water	6-oz.	106	0.0136
CS BASE	1-lb. Jar	5-gals. water	6-oz.	106	0.0111
SOUP BASE FLAVORED WITH BEEF EXTRACT	1-lb. Jar	4-gals. water	6-oz.	85	0.0108
ONION SOUP BASE	8-oz. Jar	5-qts. water	6-oz.	27	0.0296

(U.S. Measure—128 oz. Gallons)

4 POPULAR FLAVORS:—

Chicken Base—Made from fresh roasted chickens and other choice ingredients. Makes delicious soup, also imparts delicious flavor when added to chicken à la king, chicken croquettes, meat loaves and other foods. Packed in 1-lb. and new 4-lb. jars.

CS Base with Chicken Fat—Made with real chicken fat. Use it for soups, for bringing out the flavor of foods, for enriching your own soup stocks. Packed in 1-lb. and new 4-lb. jars.

Soup Base Flavored with Beef Extract—Made from the finest beef extract, monosodium glutamate, beef fat and seasoning. Makes a rich soup, also fine for seasoning roasts, hamburgers and leftover meats. Packed in 1-lb. and new 4-lb. jars.

Onion Soup Base — A complete French Onion Soup made from a carefully seasoned base and select onion flakes toasted golden brown in chicken fat, 8-oz. jar makes 5 quarts of delicious onion soup. Packed in 8-oz. and new 2-lb. jars.

Phone your Kraft branch office today for sample jars and the 12-recipe institutional book "Flavor Magic", or send a card to: Institutional Sales Manager, Kraft Foods Limited, P.O. Box 6118, Montreal 2, Quebec.

KRAFT Foods Limited INSTITUTIONAL DIVISION

KRAFT *The nation's taste is your sure buying guide*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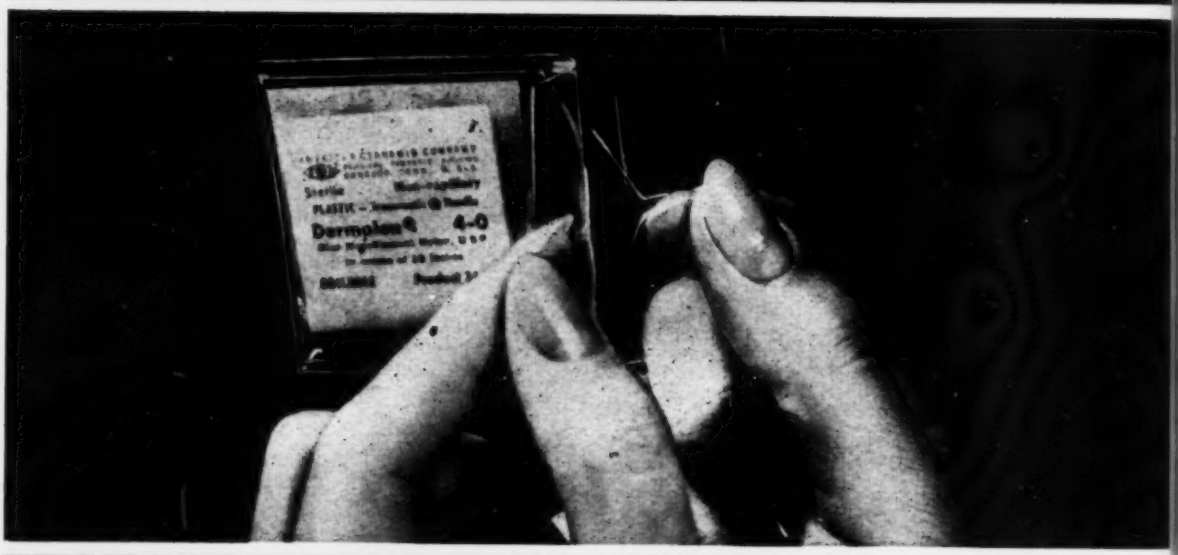
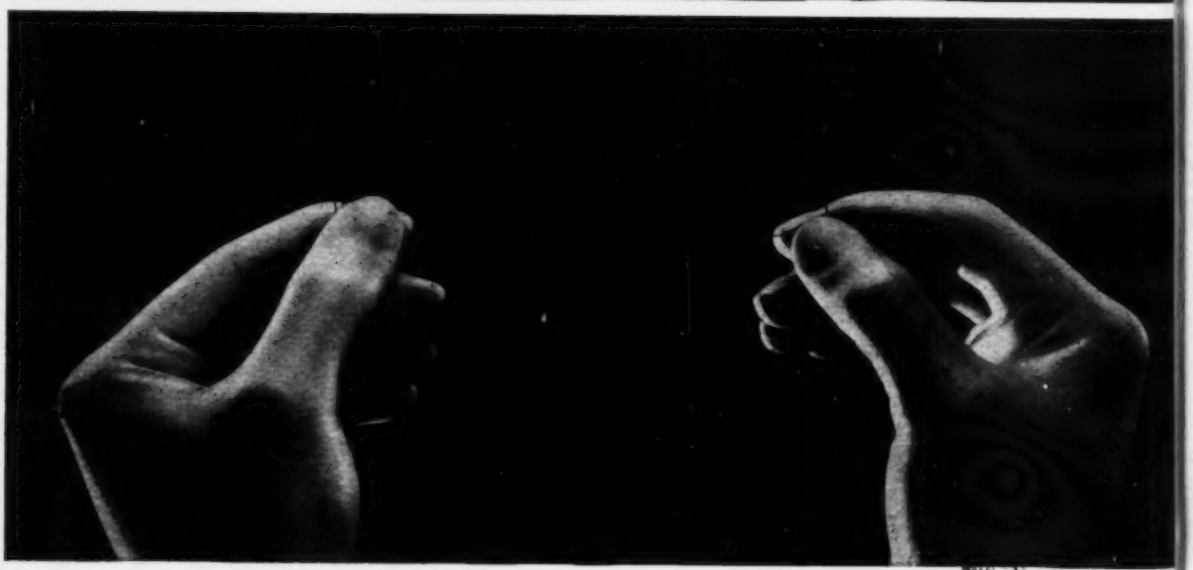
NYLON 4-0


Sterile
PLASTIK –
Dermplast
4-0



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REVOLUTIONARY D&G SURGILOPE SP*

STERILE STRIP PACK

Non-Absorbable Atraumatic® Needle Suture and Pre-Cut Lengths

THE ULTIMATE IN SUTURE PROTECTION

- No broken glass to nick sutures, damage needle points, or invade operating field
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- No awkward jars or hard-to-break tubes... excessive suture handling eliminated
- Saves time—nurse delivers D & G Surgilope SP sutures to surgeon's hand in seconds
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GREATER ECONOMY

No more breakage in shipment or handling... easier storage... less suture waste... no punctured gloves or glass in laundry

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NORTH AMERICAN CYANAMID LTD.
SURGICAL PRODUCTS DIVISION
MONTREAL, QUEBEC

Ask your Surgical Supply Dealer or SPD Representative about **D & G SURGILOPE SP,** *a complete line of non-absorbable sutures—Atraumatic needles and pre-cut lengths.*

Producers of Davis & Geck Brand Sutures and Vim Brand Hypodermic Syringes and Needles.

Notes About People

Dr. J. B. Neilson Commission Appointee

Dr. John B. Neilson of Hamilton has been appointed director of Hospital Services of the Ontario Hospital Services Commission, a full-time position which he assumes on January 20th. He has been a commissioner since July 1955.

A graduate of the University of Toronto, Dr. Neilson interned at Hamilton General Hospitals, where he became assistant superintendent in 1939. Following service overseas, he was appointed general superintendent of the same hospital in 1947.

He has been a member of the board of the Ontario Hospital Association since 1949 and has served as chairman of its executive committee. In 1955 he was elected to the board of directors of the Canadian Hospital Association.

For the past two years Dr. Neilson has been active in the work of accreditation, representing the American Hospital Association on the Joint Commission on the Accreditation of Hospitals, and is treasurer of the Canadian Commission on Hospital Accreditation as well.

New Administrator in B.C.

Ian K. Peddie has been appointed administrator to the Windermere District Hospital, Invermere, B.C. He succeeds Alan Sykes who resigned from this post last November. Mr. Peddie, who has been the assistant administrator at Windermere, had been with the Toronto General Hospital, Toronto, Ont., and with hospitals in his native England, prior to his B.C. position.

Verdun Appointment

Dr. Charles A. Roberts is now medical superintendent of Verdun Protestant Hospital, Montreal, Que. Dr. Roberts succeeds Dr. George E. Reed who retired last year. A Newfoundlander, Dr. Roberts received his medical degree at Dalhousie University and served in the Royal Canadian Army Medical Corps during the second world war. Since 1951 he had been with the Mental Health Division, Department of National Health and Welfare, serving as the principal medical officer since 1955.

J. H. Collins in New Post

J. H. Collins has been appointed assistant superintendent for the Toronto General Hospital, Toronto, Ont., as successor to the late Robert W. Longmore. For the past five years Mr. Collins has been planning director for T.G. H.'s new buildings, now under construction.

Deputy Minister for Ontario

Dr. W. Gordon Brown has been appointed to succeed Dr. J. T. Phair, who has retired as Deputy Minister of Health for Ontario. For the past year Dr. Brown has been the province's Chief Medical Officer of Health.

Dr. Brown graduated from the University of Toronto in 1928, interned in New York City, but returned to practice in Ontario. In 1934 he went as a medical missionary to Tientsin, China, and for five years was superintendent of the general hospital at I'Chang, a treaty port on the Yangtse River. He returned to Canada in 1941, and enrolled at the School of Hygiene, U. of T., receiving a Diploma in Public Health in 1942. After three years as Medical Officer of Health in northwestern Ontario, he joined the provincial Department of Public Health in Toronto.

Dr. W. G. Brown

Dr. Brown is a member of both Canadian and American Public Health Associations, and a Fellow of the Royal Society of Tropical Diseases.

Public Relations Officers

A. George Ferchat has assumed the position of director of public relations with the Ontario Hospital Services Commission. Mr. Ferchat was formerly assistant director of public relations for the Ontario Hospital Association, and for the past 18 months was assistant secretary (public relations) of the Ontario Medical Association.

B. T. McLaughlin, a Torontonian, with newspaper and public relations experience, succeeds Mr. Ferchat in the Ontario Medical Association position.

Ken Cross with the C.M.A.

Kenneth C. Cross is now assistant secretary in charge of public relations for the Canadian Medical Association. Mr. Cross comes to his new post from the Ontario Hospital Association, where he had been director of public relations since 1947.

Director of Nursing at Royal Columbian

Edith M. Pullan succeeds Susan Porrit as director of nursing at the Royal Columbian Hospital, New Westminster, B.C. Miss Pullan has been with the Provincial Mental Health Service of B.C. as director of nursing for the past 17 years, and has been active in many nursing committees at both provincial and federal levels. In 1953 she was awarded the "coronation medal" for her outstanding contributions to psychiatric nursing. She trained at Vancouver General Hospital, Vancouver, B.C., and holds a degree in nursing from the University of British Columbia.

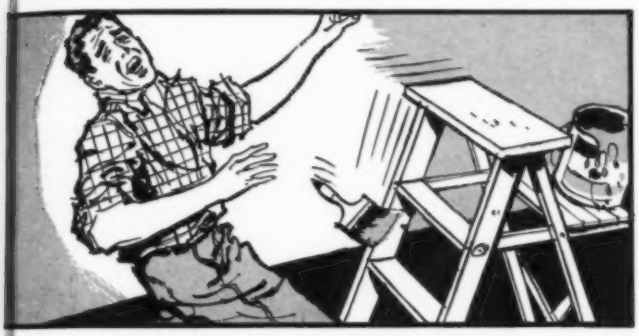
Pathology Appointment at Kingston

Dr. Douglas Waugh, former associate professor of pathology at McGill University, has been made director of the department of pathology at Hotel Dieu, Kingston, Ont. Dr. Waugh will also hold a position with the department of pathology at Queen's University in Kingston. A graduate of Manitoba University and McGill, he was certified as a specialist in pathology by the Royal College of Physicians and Surgeons in Can-

(concluded on page 24)

Neraval* allows same-day discharge

***A New Ultra-Short Acting Barbiturate for Intravenous Anesthesia**



11.00 a.m. Andy, a do-it-yourselfer—who shouldn't—sustains colles fracture, requiring immediate attention.

11.45 a.m. Neraval, ultra-short acting intravenous barbiturate, is administered. Less respiratory depression observed than with other thiobarbiturates.

1 p.m. **Recovery Room:** Andy's return to full consciousness at 12.30 p.m. attributable to Neraval's lower milligram potency and more rapid metabolism. Able to eat light lunch at 1 p.m.

4.00 p.m. Completely recovered, without "hangover", Andy is homeward-bound, thanks to ultra-short acting Neraval.

... Neraval, a new ultra-short acting barbiturate for intravenous anesthesia, is the first important advance in intravenous thiobarbiturates in nearly 25 years. Rapid recovery makes Neraval an ideal agent for use in all procedures where it is desirable to discharge the patient on the same day. Research studies with Neraval in obstetrics indicate that there is no depression of respiration in the newborn. Its excellent tolerance in the very young and very old has been recognized by all clinical research investigators.

NERAVAL Sodium, brand of methitural sodium
PACKAGING: NERAVAL Sodium Sterile Powder: vials of 1 gm., 2 gm., and 5 gm.

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MONTREAL

Ecole Superieure Mgr. Richard, Verdun, Quebec. Architect—J. Armand Dutrisac.

Plan for the Future with RUSCO

Lethbridge General Hospital, Lethbridge, Alberta. Architect—Townley & Matheson, Vancouver.

IMPROVE BUILDINGS 7 WAYS

WITH ONE PRODUCT . . . WITHOUT INCREASING COST!

1. **Increase value**
2. **Add lasting beauty**
3. **Prevent premature deterioration**
4. **Cut maintenance costs**
5. **Ensure extra fuel savings**
6. **Provide greater comfort**
7. **Provide greater convenience**

That's a lot of improvement to accomplish simply by including one specific product in your plans. But Canadian architects from coast to coast are *doing it* with RUSCO STEEL PRIME WINDOWS.

HOW RUSCO INCREASES VALUE WITHOUT INCREASING COST

While Rusco windows are a quality product and priced accordingly, *their overall installed cost is usually less than any window on the market.* Complete prefabrication *eliminates* all costly on-the-spot labour of fitting, adjusting, glazing, weatherstripping and painting. Installation often takes as little as 5 minutes.

HOW RUSCO ENSURES LASTING BEAUTY

Rusco's tubular steel frames are hot-dipped galvanized, bonderized and painted with best quality outdoor enamels . . . *baked on,* to last, like the finish of a new car.

HOW RUSCO PREVENTS PREMATURE DETERIORATION

Rusco windows have best quality waterproof-felt weatherstripping *built in.* Glass is bedded in glazing compound and held in place with vinyl plastic spline. There's no unsightly putty to chip or crack.

Rusco's superior weatherstripping prevents leaks and water damage.

Rusco's Fiberglas screens won't rust, rot, burn or stain and never need painting.

HOW RUSCO CUTS MAINTENANCE COSTS

Rusco windows are comparatively inexpensive to clean. The sliding glass panels can be quickly and easily removed from the inside.

They're easy to repair too. Glass panels are interchangeable. Spares can be substituted when necessary and broken glass replaced in the maintenance shop.

Furthermore, Rusco windows have no sash cords, weights or levers to get out of order.

HOW RUSCO ENSURES EXTRA FUEL SAVINGS

In addition to the superior insulating qualities of Rusco Prime Windows, Rusco insulating sash (optional) can be added as an integral part of each unit to provide substantial extra savings on fuel.

HOW RUSCO PROVIDES GREATER COMFORT

Rusco insulating sash also provides controlled, year-'round rainproof, draft-free, filtered-screen ventilation.

HOW RUSCO PROVIDES GREATER CONVENIENCE

Rusco windows operate easily, slide smoothly and silently in felt-lined channels; lock automatically either open or closed.

Available in a wide range of types and styles in all standard sizes, Rusco windows can be used in almost any multiple combination desired.

For complete details call or write your nearest Rusco distributor

RUSCO PRIME WINDOWS

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also 1223 Kensington Rd., Calgary
Construction Products, 3044 Beresford St., Burnaby, B.C.

The Extension Course in
Hospital Organization and Management

Enrol Early for 1958 Class

All those interested in enrolling in the 1958 class of the extension course in hospital organization and management should submit applications not later than March 31st. The course commences in early September. Because the demand for enrollment continues to be be heavy, assurance can not be given that applications arriving late will be considered.

The two-year program is now in its seventh year, and the certificate of graduation given by the Canadian Hospital Association has been granted to 250 persons. Those enrolled in the course spend eight months each year studying lessons at home and preparing assignments. This period is followed by an examination and a four-week intramural summer session at a specified Canadian university.

Information and application forms may be obtained by writing to: The Secretary, Committee on Education, Canadian Hospital Association, 280 Bloor Street West, Toronto 5, Ontario.

Hydrotherapy Pool for Manitoba

The $100,000 hydrotherapy pool for polio patients at the Princess Elizabeth Hospital in Winnipeg, Manitoba, was officially opened in 1957.

This project, culminating the fund-raising efforts of the Fort Garry Kiwanis club and assisted by provincial and federal governments, interested groups, firms, and private citizens, was begun in 1955. At this time it was learned that the pool of the HMCS Chippawa, formerly used by the hospital, could only be loaned by naval authorities until a new pool could be built for polio patients.

The new pool measures 14 feet by 24 feet; and its depth in four-inch graduations varies from 3 feet, 6 inches, to 5 feet, 6 inches. The water is heated to between 80 and 90 degrees. Each treatment lasts up to half an hour. In the same room as the pool are two whirlpool baths for treatment of arms and legs, and a Hubbard tank.

These new facilities will offer treatment to all patients in the province requiring hydrotherapy. —*The Beacon.*

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of a NEW standard
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You and the man from Salada-Shiriff-Horsey have a most important common interest. We both demand the most efficient food servicing in Canada!

We both want to hold the line in the critical area of food costs.

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We both seek ever more efficient portion control, brighter menus, better trained technical men.

The wealth of experience of these three great family businesses is dedicated to maintaining these objectives.

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▶LOOK TO THE *NEW* SALADA · SHIRRIFF · HORSEY FOR . . .

NEW! ***PRODUCTS . . . for menu excitement.***

NEW! ***PORTION CONTROL . . . to check your expenses.***

NEW! ***RESEARCHED RECIPES . . . to save you time.***

NEW! ***FOOD PREPARATION STUDIES . . . to help your planning.***

The man from **SALADA · SHIRRIFF · HORSEY Ltd.**

knows how to cut food costs!

Rx: For Persons Allergic To Natural Rubber... ROLLPRUF® Neoprene Surgical Gloves

Hospital-green, soft-textured, non-allergenic neoprene. Flat-banded cuff won't roll down. Multi-size markings for easy sorting.

the PIONEER Rubber Company Willard, Ohio, U.S.A.

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...and Quixam® Neoprene Examination Gloves, too. One glove fits either hand.

Picture a **SAVING...**

Compare . . .
Convenience . . . Cost . . .

AEROPLAST ***a "spray-on"*** **Surgical Dressing replaces conventional gauze and tape**

Now, a new yellow-tinted aeroplast which shows a faint yellow film, immediately controlling the tendency to overspray and undesired flooding and also clearly identifying the area dressed. Clinical advantages remain unchanged.

Aeroplast provides a new efficient economy and versatility as a protective dressing for routine use in surgical and traumatic wounds, burns, abrasions, excoriation, etc.

Aeroplast dressings are tough and flexible —they withstand washing, yet can easily be removed by the simple process of "peeling".

Aeroplast dressings are economical and several factors contribute to this economy: (a) Each 6 oz. dispenser will dress approximately 565 square inches. If gauze and tape were used approximately 500 4-inch gauze squares and almost 100 yards of adhesive tape would be required. (b) Aeroplast is always sterile, (c) takes little storage, (d) obviates the need for varied sizes and shapes of dressing materials.

Aeroplast is non-toxic, non-sensitizing, non-allergenic, anti-bacterial and occlusive. Supplied in 3 oz. and 12 oz. (tinted) and 6 oz. (clear) Aerosol-type dispensers.

Distributed in Canada by

Fisher & Burpe Limited

PHYSICIANS' AND HOSPITAL SUPPLIES

MONTREAL TORONTO WINNIPEG EDMONTON VANCOUVER

ada in 1954. His training included service with the Montreal General Hospital, Montreal, Que., the Children's Memorial Hospital, Montreal, the University of Alberta, where he was an associate professor and a member of the Alberta Cancer Diagnostic Clinic, and with the McGill Pathological Institute.

Assumes Nursing Post in Newfoundland

Helen Penny, R.N., has been appointed as the associate director of nursing service at St. John's General Hospital, St. John's, Nfld. Miss Penny graduated from the St. John's General Hospital School of Nursing in 1949 after serving with the R.C.A.F. Women's Division as an aerial photographer. She also has done post-graduate study in public health nursing at the University of Toronto, Toronto, Ont. Until her present appointment, Miss Penny has been a health instructor at the St. John's General Hospital.

Chief of Staff at South Peel

Dr. L. G. Brayley of Port Credit, Ont., has been appointed chief of staff for the South Peel Hospital, Cooksville, Ont. Dr. Brayley ran a hospital in England during the war, was for a time in charge of the Oakville Rehabilitation Centre, and later, served at the Hamilton Military Hospital. He took up medical practice in Port Credit after his discharge from military service, and has been a member of the building committee of the South Peel board of governors.

New Supervisor at Sutherland Memorial

Jean Baird, R.N., has assumed the duties of superintendent of the Sutherland Memorial Hospital, Pictou, N.S. Mrs. Baird, a native of Stellerton, N.S., is a graduate of the Victoria General Hospital in Halifax and has been a floor supervisor at Aberdeen Hospital, New Glasgow, N.S. She succeeds Ethel Elliot, who recently resigned from the Sutherland post.

• Named new head of the social service department of the Montreal General Hospital, Montreal, P.Q., is Jessie M. Lawrence. She succeeds Avis Pumphrey who has returned to the west coast to be director of that department at the Vancouver General Hospital, B.C.

• Mrs. L. P. LeBeau has been appointed matron of the Armstrong and Spallumcheen General Hospital, Armstrong, B.C.

• Dr. Newell W. Philpott, professor of obstetrics and gynaecology at McGill University, Montreal, Que., has been named president-elect of the American College of Surgeons.

• Dr. Lyle A. Jentz has been appointed pathologist at the Brantford General Hospital, Brantford, Ont. He succeeds the late Dr. W. J. Holley.

• Ernest O. Hodge has left the Yarmouth Hospital, Yarmouth, N.S. to take up the position of administrator at the Colchester County Hospital in Truro, N.S.

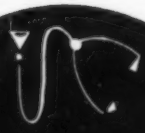
• Sister Prevost, formerly superior of St. Margaret's Hospital, Biggar, Sask., has been transferred as sister superior to St. Paul's Hospital, Saskatoon, Sask.

No man, for any considerable period, can wear one face to himself, and another to the multitude, without finally getting bewildered as to which may be the true.—*Nathaniel Hawthorne.*

Everybody benefits from this new, long-acting sulfa that cuts dosage over 75%

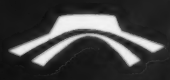
Administrative Staff
—reduces inventory... simplifies stock control and handling

Pharmacist
—a real space-saver... 1 tablet a day does the work of 8 other sulfa tablets



Doctor
—especially indicated in urinary tract infections with negligible risk of crystalluria

Patient
—greater acceptability... unbroken sleep



Nurse
—a time and step-saver... a single maintenance dose provides 24 hours antibacterial activity

Tablets: Each quarter-scored, peach-colored tablet contains 0.5 Gm. (7½ grains) of sulfamethoxypyridazine. Bottles of 24, 100 and 1000 tablets.

Syrup: Each teaspoonful (5 cc.) of caramel-flavored syrup contains 250 mg. of sulfamethoxypyridazine. Bottles of 4 fl. oz.

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KYNEX*

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Lederle CANADA

Putting full 200-ma power on wheels, this G-E unit brings new dimensions to x-ray versatility, as shown in . . .

the morning rounds of

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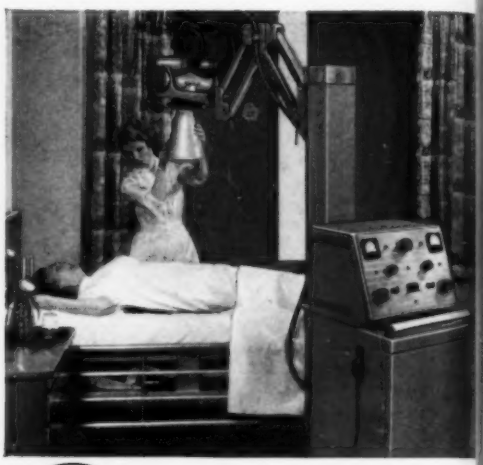

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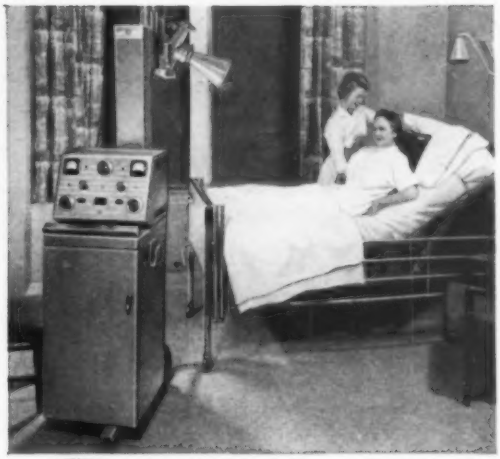

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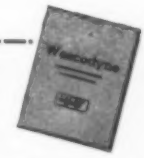

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W. Douglas Piercey, M.D., Editor

The Canadian Hospital

Obiter Dicta

Hospital Insurance

THE concept of prepaid hospital care has developed rapidly during the past two decades. In the vanguard were various Blue Cross plans and contracts offered by insurance companies, followed by provincial government-sponsored programs. An outstanding feature of these programs was the rapidity with which the idea of prepaid hospital care was accepted by many Canadians.

Prior to the enactment of Bill 320 on April 10, 1957, by the federal parliament, four provincial governments had established hospital insurance plans. Saskatchewan was the first, starting in 1947, and British Columbia followed in 1949. Alberta adopted a provincial grant-in-aid program to subsidize municipally administered hospital care plans; and Newfoundland, prior to becoming part of Canada, had a plan which maintained hospitals in isolated areas, staffed them with professional groups and made essential hospital and medical care available to local residents.

The idea of a national hospital insurance plan for all citizens of Canada had been discussed for many years. It became a major issue of public policy, advocated by all national political parties. Debates in the House of Commons prior to the passing of Bill 320 centred on details of how far-reaching the bill should, or should not be, rather than on the general desirability of a hospital insurance policy. Essentially, Bill 320 provides a method whereby the federal government offers assistance to those provinces who are willing to enter into an agreement for the establishment of a provincially-sponsored hospital insurance plan under the terms of the federal Bill. An essential feature of the Bill is that it will not become operative until six provinces, representing the majority of the population of Canada, enact similar legislation, sign agreements with the federal government, and have plans in operation. To date the provinces of British Columbia, Saskatchewan, Alberta, Ontario, Newfoundland, and Prince Edward Island have signified their intention of taking part in this program. In addition, hospital insurance is under close study in the provinces of Manitoba, New Brunswick, and Nova Scotia.

Because of wide-spread interest in hospital insurance at present it was to be expected that this topic would be a major item on all convention programs of hospital associations during 1957. Many provincial governments took the opportunity of reviewing their plans where these were already in operation, or of explaining plans to be introduced. Thus the government of Alberta, through the Minister of Health, the Honourable J. B. Ross, M.D., and Professor J. D. Campbell, Director, Hospitals Division, Department of Health, outlined the proposed provincial plan at a session of the Associated Hospitals of Alberta convention. (see *Canadian Hospital*, Dec., 1957, page 43).

Many details of the Ontario plan were explained at the 33rd convention of the Ontario Hospital Association. An address was given by Premier Frost, and a symposium presented by A. J. Swanson, Msgr. Fullerton, E. P. McGavin, and David Ogilvie clarified the details. The Ontario Hospital Association has published this symposium in booklet form, and has made it available to all their member hospitals. Because we believe that this material will have wide interest beyond Ontario, we are devoting a major portion of this issue to three of the symposium addresses. The fourth, on hospital budgets by E. P. McGavin, will be published in a subsequent issue of this journal.

Routine Chest X-rays No Radiation Hazard

THE success which has attended the control of tuberculosis during the past decade has been due in no small measure to the wide-spread use of routine chest x-rays. This has accelerated case-finding activities and has assisted greatly in early diagnosis. Technical advances in the manufacture of photo-flurographic equipment have made possible the rapid taking of many low cost miniature chest x-rays. The development of community and mass survey techniques and the introduction of the admission chest x-ray program in the general hospital followed. It is estimated that more than 3,000,000 persons in Canada are provided with free chest x-rays each year, and more than 600,000 patients annually have chest x-rays on entering hospitals.

In the light of such spectacular advances in the control of this ancient scourge, tuberculosis workers read with consternation recently of warnings against periodic chest x-rays as part of the radiation hazard picture. In these days when radiation danger from nuclear tests is very much in the

news, it is only natural that the public should take great interest in comments on the dangers of radiation in general. The last issue of the Bulletin of the Canadian Tuberculosis Association discussed this this question and, on the basis of pronouncement by experts, it is reassuring to learn that periodic chest x-rays, even if given annually, would provide such a small excess of radiation as to be of minimum significance and quite below any suggestion of danger. As there is every reason to believe no hazard results from community chest x-ray programs which are now in operation throughout Canada, all of us can return with renewed vigour to our objective of making tuberculosis as rare a disease as typhoid.

It Could Happen to You

ANY hospital, large or small, should be organized to meet a large influx of patients in case of a civilian disaster. Hospitals cannot afford to neglect this responsibility if they are to discharge their complete obligation to the community. This has always been the case. However, because we now live in what is called the atomic age, the hospital has a further duty of planning for a possible national emergency. Adequate planning involves close liaison between the many groups within the hospital and the community.

Although considerable publicity has been given to hospital disaster programs over the past few years and several institutes on the subject have been held, one wonders how well prepared most Canadian hospitals actually are. This question applies not only with the thought of national emergency in mind, but even in the event of a local disaster such as a train wreck, an explosion in an industrial plant, or heavy floods.

As responsible Canadian citizens hospital administrators have no right to defer disaster planning from day to day, or from week to week. The difference between an effective disaster plan and *no* plan can mean the difference between adequate care for many people and tragic chaos. This responsibility is yours. The fact that your community has never suffered any great natural calamity does not mean that it will be forever immune. Experience over the past decade has taught us that disaster strikes only too often. In such a situation an ounce of preparedness is worth much frenzied activity at the last minute.

In 1953 Dr. A. L. Swanson attended regional meetings of the Civil Defence Health Services Planning Committee in three Canadian centres. He was impressed by what he learned of hospitals' civil defence preparations—unfortunately the impression was uniformly unfavourable! He wrote then: "Most Canadian hospitals appear to have done little if any concrete planning in case of a possible disaster. In some there is a general plan in the minds of a few top personnel but that would be of little avail were disaster to wipe out these very individuals. Many hospitals admit having no plan whatever."

Some five years later, your present editor wonders if there has been much improvement. We would like to be able to say categorically that 80 per cent of all Canadian hospitals have a disaster plan, not only on paper, but one they are prepared to place in operation on the shortest notice. If we could say that even 50 per cent of all hospitals had a disaster plan, we would be relatively happy and feel that much progress had been made. Perhaps a nation-wide survey, to ascertain definitely the present status of each hospital with regard to disaster planning, would be of value.

Cela Peut Vous Arriver

TOUT hôpital, grand ou petit, doit être organisé pour pouvoir admettre un grand nombre de victimes en cas de désastre civil. Les hôpitaux ne peuvent se permettre de négliger cette responsabilité s'ils doivent s'acquitter de toutes leurs obligations envers la communauté. Cela a toujours été. Cependant, du fait que nous vivons à l'age dit "atomique", l'hôpital a en outre le devoir de se préparer à l'éventualité d'une calamité nationale. Une préparation convenable implique une liaison étroite entre de nombreux groupes de l'hôpital et de la communauté.

Bien qu'une large publicité ait été faite ces dernières années à la préparation des hôpitaux aux désastres et que plusieurs réunions d'information se soient tenues à ce sujet, on se demande quel niveau de préparation ont en fait atteint la plupart des hôpitaux canadiens. On se le demande en pensant non pas seulement à une calamité nationale, mais aussi à un désastre local comme une catastrophe ferroviaire, une explosion dans une usine, ou de graves inondations.

En tant que citoyens canadiens responsables, les administrateurs d'hôpitaux n'ont pas le droit de remettre de jour en jour, ou de semaine en semaine, cette préparation aux désastres. La différence entre une préparation efficace et *pas* de préparation *du tout* peut se traduire par différence entre des soins convenables pour beaucoup de gens et un chaos tragique. Cette responsabilité est à vous. Que votre communauté n'ait jamais souffert d'une grande calamité naturelle ne signifie pas qu'elle en soit à jamais protégée. Ces dix dernières années nous ont appris que les désastres n'arrivent que trop souvent. Dans ces cas là un peu de préparation est plus utile qu'une activité frénétique à la dernière minute.

En 1953, le Docteur A. L. Swanson a assisté à des réunions régionales de la Commission d'Organisation des Services de Santé de la Défense Civile (Civil Defence Health Services Planning Committee) dans trois centres du Canada. Il fut impressionné par ce qu'il apprit sur les préparatifs de défense civile des hôpitaux—impression hélas presque uniformément défavorable! "La plupart des hôpitaux canadiens," écrivit-il alors, "semblent avoir fait bien peu, si tant est qu'ils ont fait quelque chose, en ce qui touche la préparation concrète à l'éventualité d'un désastre. Dans certains, quelques membres du personnel dirigeant ont en tête un plan d'ensemble mais cela ne servirait guère si ces personnes étaient elles-mêmes victimes du désastre. Beaucoup d'hôpitaux admettent qu'ils n'ont pas le moindre plan."

Quelques cinq ans plus tard, votre rédacteur en chef actuel se demande si cette situation s'est beaucoup améliorée. Nous voudrions pouvoir affirmer que 80 pour cent des hôpitaux canadiens ont un plan en prévision d'un désastre, pas seulement sur le papier, mais prêt à être mis en pratique dans le moindre délai. Si seulement nous pouvions dire que 50 pour cent de tous les hôpitaux ont un plan en prévision d'un désastre, nous serions relativement heureux et nous estimerions qu'un grand progrès a été fait. Peut être une étude destinée a déterminer, pour le pays tout entier, quelle est la situation de chaque hôpital en regard de la préparation aux calamités, serait-elle des plus utiles.

STATISTICS –

Can They Forecast Future Health Needs?

Lloyd Williams,
Regina, Sask.

THE use of statistical data to measure the detailed quantitative aspects of hospital care for a large population group is fairly new. It is even more novel to employ these data to measure qualitative aspects. Newer still is the attempt to venture into prediction of future hospital and health care requirements based on scientific observation of the kind of hospital care being received by such a group today.

Perhaps it may be assuming too much to say that ten years ago, when the Saskatchewan Hospital Services Plan was introduced, planning officials and administrators foresaw the full range of possibilities when they established research units for fact-finding and statistical analysis. But the opportunities and the challenges were too attractive to be passed up. New types of statistical data were emerging as a result of such routine administrative operations as beneficiary registration, eligibility determination, and payment of hospital accounts.

What were these opportunities, and what were the challenges? To take the opportunities first, there was the fact that, for the first time in any such program in Canada, data which were referable to the entire population were becoming available. Trends in utilization could be taken as reflecting the demands and presumably the needs of this population, since there did not exist any preselection of favourable or unfavourable risks. Moreover, the population "at risk" would be comparable from year to year. This is a fairly important matter when studying trends in utilization and in costs. As discovered with many health plans, it is difficult to make valid comparisons when the composition of the beneficiaries has an annual turnover which can reach 25 per cent.

The third point of interest about the covered population of the Saskatchewan plan was that the data arising from its operations would be timely and reasonably accurate. This may sound like belabouring the obvious, but it is surprising how difficult it is to obtain health services information which is consistent in time, covers a uniform geographic area, and is reported quickly.

Knowledge of the covered population (which is to say, in Saskatchewan, the entire population) then became the cornerstone for statistical analysis. All morbidity and utilization data could be related quickly to the "denominator" data which was specific for age and sex, family size, and residence.

Challenges

What kinds of questions required answers? How were the facts at hand going to be used?

The first objective was, of course, to use hospitalization data to understand more fully the operations of the insurance program. The second objective was to determine if, where, and when controls were necessary in the interests of developing a comprehensive component of a health service. The third objective was to attempt evaluation of hospital care services and facilities in qualitative as well as quantitative terms.

All hospital care plans, of course, keep adequate financial statistics. Indeed, for many plans this is the sole reason for compiling statistical data. Several plans also keep records relating to services. But, for the most part, these are compiled in an endeavour to ascertain so-called overuse rather than to evaluate and point up improvements in the quality of care. It is a fairly simple matter to maintain statistics of utilization so that financial controls can be exercised to "protect a fund". Much more difficult is the task of assembling these data to discover whether, for example, ageing people among the beneficiaries need more hospital care than the average; or whether the care they are receiving is adequate to meet their needs; or whether the methods of disbursing the funds required represent the most efficient and judicious expenditure of what have become, in essence, public funds.

The paragraphs to follow will mention some of the problems to which greater insight was sought and will touch, also, upon some of the findings arising out of Saskatchewan's hospitalization experience since 1947. The concluding paragraphs will draw attention to a few of the program changes suggested by these findings. In practically no instance was it possible to isolate a finding which could be said to be a generalization. Instead, the findings, to be meaningful, had to be referable to age groups, to specific areas and to specific diagnostic conditions. A need which was being met in one area with one type of hospital facility and with a given pattern of hospital utilization might, in another area, be met with a quite different type of hospital and quite different admission and discharge rates.

Variations in Use

In Saskatchewan the volume of care in general hospitals levelled off a few years ago—some four years subsequent to the introduction of the insurance plan—at a plateau of approximately 200 admissions for every 1,000 bene-

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Mr. Williams, a research economist with the Department of Public Health (Sask.), gave this paper during a panel discussion at the Manitoba Hospital and Nursing Conference, October, 1957.

ficiaries, which is one admission for every five persons in the covered population. Note that this represents a province-wide average. It soon became known that in some areas one person in three was being hospitalized in a year, while in other areas it was not more than one person in eight or nine.

Several studies were carried out in an attempt to isolate the underlying factors producing these variations in hospital use. Even a cursory examination of the Saskatchewan program was sufficient to prompt a number of questions: What were the reasons for the rise in utilization during the first three years of operation of the insurance plan? Could the high plateau in volume of care be expected to decline? What accounted for certain striking regional and local differences in utilization? Were urban and rural differences to be explained by variations in sickness and accident rates, by the prevailing practices of physicians, by underlying social and economic factors, or by a combination of all of these?

One study sought to throw light on such questions by comparing areas in the province with the highest and the lowest utilization rates and relating the hospitalization experience in these areas to a number of relevant attributes. From this analysis it became possible to define a profile of demographic and social characteristics in comparable areas with the highest and the lowest rates of utilization.

Greater rurality, low population density, larger families, and greater distances from large cities—these were found to be important social factors in areas of highest use. Similarly, land values were found to be less in the so-called "high" areas.

Since it is reasonable to associate poorer housing with less productive land, the higher utilization could be said to be part of the price paid for the inadequate resources of home care.

Other studies had demonstrated that a correlation existed between bed-population ratios and utilization when the framework was prepayment that included every eligible person in the population. These facts were confirmed by the "high-low" investigations which showed that there is a greater ratio of beds in the high utilization areas. Moreover, higher utilization was found to be associated with a smaller supply of physicians.

The interaction of the many social and professional forces at work was expressed in the way hospitals were used for the care of varying illnesses. Thus, in those more rural areas with exceptionally high utilization, patients with influenza, pneumonia or bronchitis were admitted four to six times as frequently as similar patients in the contrasting urban areas of exceptionally low utilization. City patients with respiratory illness were admitted less frequently but, interestingly, for longer periods of stay. In other words, the less seriously ill cases in the large urban centres were more likely to be cared for at home. What was learned, then, is that the phenomenon of higher-than-average utilization is better understood as the combined product of many conditions rather than the result of, say, personal whim on the part of the patient or his doctor. This important observation deserved much closer study and led to analysis of the problem of why people—why Saskatchewan people, at any rate—go to hospital.

Repeaters

One of the most important and baffling causes of high admission rates to hospitals, it has been found, is the existence of a small hard core of chronically ill repeaters. These are persons who are hospitalized two, three, and up to nine or ten times in a five-year period. They account for more than one-half of all general hospital services provided. It is a sobering fact that any solution to the problem they pose is difficult and probably beyond the scope of the individual hospital administrator.

What was discovered was that —even in Saskatchewan with its high admission rates—most people who are hospitalized are not what might be called members of a sickly group.

Since, on the average, one person in five of the population is admitted each year, each resident should expect (on theoretical grounds) to be occupying a hospital bed at least once in a five-year period. What actually happens is that two-thirds of the people in the general population are not sick enough in any representative five-year period to be hospitalized at all and the majority who are sufficiently ill are hospitalized only once or twice. Relatively few receive a great deal of hospital care.

These repeaters, in fact, form such an important segment of the population that, if no patient were admitted more than once in a five-year period, the utilization of hospitals would, practically overnight, be reduced by almost 45 per cent.

Who are these presumably less healthy people? Are they hypochondriacs — those patients who can be identified by the changing labels of their many ailments? Are they rich or poor, country folk or city dwellers?

From the Saskatchewan data it was discovered that repeaters are persons who are more likely to be living in small towns and villages rather than large cities. The explanation for this observation is not yet quite clear. Possibly many of them are older farmers and their wives, now living in the villages, who cannot get proper care at home or who cannot be seen often enough in their homes by their own local doctor. Then, too, it was learned that repeater patients are often the lonelier persons in the community. Among men, they include many who are widowers, bachelors and those divorced and separated from their wives. There is additional evidence, in fact, that a state of continued marriage is not the only important factor in avoiding hospitalization among men. Men who are married also have significantly shorter stays in hospital.

It has not been too difficult to draw diagnostic as well as demographic profiles of the repeaters. The majority of them are persons with certain well-defined and serious physical ailments. They tend to be afflicted with malignant cancers, or allergic disorders, or hypertension, or heart diseases of various kinds. Allergic disorders account for more repeat admissions than any other single cause. People with arthritis and arteriosclerotic heart disease can expect, on the average, to be in hospital about twice annually, year after year, and to stay two or three weeks with each visit—that is, about twice as long as the province-wide average stay of 10 days—and most of their admissions will be for the same conditions.

By way of contrast, people hospitalized for appendicitis, acute tonsillitis, or abdominal hernia experience few, if any, repeat ad-

"Morning Shadows"
by Dr. E. V. Spackman,
Lethbridge, Alta.

missions in any representative five-year period. What is deduced then, when the hospitalization experience of the province as a whole is considered, is that most people experiencing repeat admissions to hospitals are not occupying beds for trivial reasons. They suffer from diseases which last many years and which are subject to acute flare-ups.

The next question to ask, from the Saskatchewan experience at least, is how can repeat admissions be reduced? Some answers are fairly obvious. Financial deterrents levied on the patient represent one method, although obviously these seriously ill persons would be very hard hit by cost-sharing devices. From the standpoint of an improved health service, reductions in repeat admissions can probably be best effected by making more health care available in homes, by improving housing, and perhaps by equipping doctors' offices and clinics so that certain diseases and conditions can be medically managed outside the hospital.

How these alternatives are to be brought about or whether they have already been worked out in other provinces and in some parts of Saskatchewan, are additional matters which may or may not be beyond the policy-making and administrative functions of the hospital care service. What is intended here is to show the manner in which statistical research in a hospital care plan can be used to point up and define some of the hospital care needs of tomorrow.

Accommodation

Hospitalization data, referable to the entire population, can be used, also, to define other health care problems, even though these problems are not directly associated with hospital care as such.

Take hospital accommodation as one example. When a hospital plan is introduced which covers everyone, the beneficiaries become highly conscious of their right to a hospital bed when they need it. This is one explanation for the accelerated pace of hospital construction that follows. Inevitably, pressing problems are raised as to where new hospitals should be located, which hospitals should be extended, and how many beds are required in each.

Statistical data which are assembled primarily for the administration of a prepayment organization have become reliable guideposts for determining basic policies in hospital construction programs, and for elevating standards of hospital care. Analysis of hospital utilization experience is proving to be a useful and objective instrument for measuring local bed requirements. From these data it has been learned that there is no one requirement—there are a great many. In some parts of the province the requirements are already met. In others, much remains to be done.

Quite clearly, any province which puts its prepayment statistics to work will throw additional light on the nature of its own hospital care needs; and these are almost certain to be different from those in Saskatchewan.

Quality of Care

Possibly the field of research which has proved to be the most difficult and yet the most intriguing has been in applying hospital utilization data to problems connected with the qualitative aspects of health care. A few examples will illustrate the kinds of opportunities afforded.

The quality of surgical care in small hospitals of less than 25 beds has been examined through the medium of utilization statistics. The question posed here was whether major surgical procedures should be performed in small units with limited facilities. The studies proceeded in this way: Hospitalization data on the incidence of specific surgical procedures in these institutions was related to the presence of surgical assistants, medical or non-medical anaesthetists, type of anaesthesia, and other relevant factors. This approach has been most useful. The data, comparable among hospitals of the same size, and comparable from one year to the next, are providing an objective base-

(concluded on page 72)

The Ontario Commission and its

Hospital Insurance Program

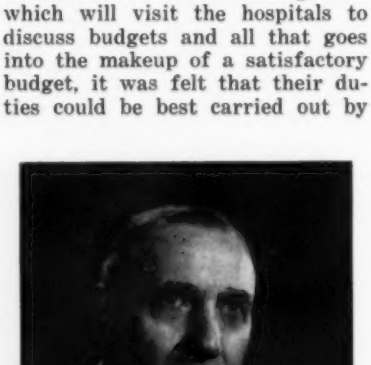
Looking Inside the Commission

Arthur J. Swanson,*
Toronto, Ont.

LET us take a look at the general development of the Ontario Hospital Services Commission. On glancing back over the past two years, I cannot help but feel that there are four important dates to bear in mind. The first is April 1955, when discussions on hospital insurance took place between provincial and federal officials. It was at the insistance of Premier Frost that this subject was included in the agenda at that time. This first step resulted in several other meetings which led to the second important date, January 26, 1956, when the Hon. Paul Martin announced that the federal government would participate in the hospital insurance program and explained to what extent they would participate. This again resulted in a number of meetings as several points in his announcement needed clarification. The third important date was March 4, 1957, when, at a meeting in Ottawa, the Hon. Mr. Martin finally agreed to a proper interpretation of the words "universally available". The Ontario officials insisted that these words meant that the program should be made available to everybody, but Mr. Martin insisted that they meant compulsory. It was quite a difficult meeting on that date, but Mr. Martin finally gave way. The next important date was October 25, 1957, when the announcement of the terms of the Ontario plan in detail (see page 42) was made to the press, the radio and television stations.

There were other dates that had definite importance—such as April 1957, when the federal Bill 320 was enacted, and the dates 1956 and 1957, when the provincial Bills 112 and 165, the Hospital Services Commission Acts, were passed.

There was not too much action until we had finally settled with Mr. Martin that we were going to get under way on a reasonable and sound basis. Immediately we started to make additions to the staff, for we felt that any staff coming to us for either inside work or duties in the field would have to be thoroughly trained. For instance, in the case of the accounting staff which will visit the hospitals to discuss budgets and all that goes into the makeup of a satisfactory budget, it was felt that their duties could be best carried out by persons with not only accounting experience, but hospital experience as well. We have appointed a highly qualified chartered accountant to head this service. He has on his staff a second chartered accountant as well as several other accountants who have not only been put through a rigorous course of training, but have been visiting hospitals in order to familiarize themselves and hospital administrators with what will be expected of them when the plan goes into operation.



A. J. Swanson

We set up a division of training programs under the direction of John Hornal. He has been working with the various groups in this area where we feel there is a definite shortage of staff, in an endeavour to arrange for the setting up of centres of training, recruitment, and all the other facets of a training program.

Other departments set up were research and statistics. The research department was a vital one, for it examined the pertinent figures, as well as continually carrying out financial studies in order that we might have a clear picture of how the complicated Ottawa formula would affect *our* program. The division of statistics was set up to carry out constant studies relating to the utilization of hospitals and all aspects of occupancy. These figures prove invaluable when applications for additional beds are reviewed.

We have attached to the Commission a medico-legal consultant who reviews our documents, in addition to the routine work of screening all hospital by-laws.

The articles in this symposium are from addresses given at the Ontario Hospital Association Convention in October, 1957.

**Mr. Swanson is chairman of the Ont. Hospital Services Commission.*

These departments are all kept busy continually — in keeping up with the routine work of the Commission, and in coping with the added work of the insurance program.

We have kept in continual contact with special committees which were set up by groups who were particularly interested in how the people they represent would be affected. Perhaps most important was the special committee which was appointed by Mr. Frost to work with the Commission. They have been invaluable. I also want to pay tribute to the co-operation we have had from all the staff of the Ontario Hospital Association and their Blue Cross Division.

We have been fortunate in having associated with us as consultant to the Commission, Professor Malcolm Taylor of the University of Toronto's department of political economy, who is, no doubt, the best informed authority in Canada on health and hospital insurance. His advice, too, has been invaluable and is another factor in making our job very much easier.

The actual details concerning the rates and benefits could not be worked out until we had some directive from Ottawa, and we did not arrive at a sound starting place until March 4, 1957. We have had to study the regulations prepared by Ottawa. We have had to draft our own regulations and scheme of administration, and above everything, carry out many complicated studies which, of necessity, entered into the rate structure.

You will realize that in a number of instances we had very little to go on in the way of experience since the program was to be so comprehensive. No other insurance had been written to give such broad coverage to the entire population whether in general hospitals, long-term hospitals, convalescent, hospitals for the mentally ill, and tuberculosis sanatoria. This study entailed much detail as the Ottawa formula was not quite as simple as it looked, and we had to project our figures to procure the maximum financial benefit possible under the formula. When we had completed our calculations, after some months of intensive work, we called in a firm of independent actuaries to check our figures and arrive at safe rates. We made our data available and they also secured information from outside sources. It is significant to note that they arrived at the same figures as the officers of the Commission had.

However, rates were only one facet of the problem. We had to study another important document from Ottawa—the draft of the federal regulations which set out much of the detail of operation. I think we have had six drafts of this document to the present time.

We have had to draft our own regulations and this is also a very important and rather voluminous document. It had to conform in detail to the Ottawa documents, but had to apply to our own provincial ideas of operating as well. We also have under way a document known as the Scheme for Administration which sets out in detail many of the requirements of the actual administration.

We have a constant liaison with many important committees. The Ontario Medical Association set up a strong committee and that organization has been kept advised of the progress we were making. We must have the full co-operation of the medical profession, particularly in admissions and discharges, if the plan is to be a success.

A committee of the Canadian Manufacturers' Association was set up, which consisted of eleven representatives from the largest employers of labour. We feel that by keeping closely in touch with them we achieve good public relations.

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The 1959 Approach

D. W. Ogilvie,*
Toronto, Ont.

ONTARIO's 1959 approach to prepaid hospital care is a large and significant step forward in a field which has seen a remarkable transformation in the past two decades. All of us can recall the situation in 1939, when there were almost no facilities available for people in Ontario to pay for hospital care before they were hospitalized. Then in 1941 hospitals provided a prepayment mechanism, Blue Cross, under which by 1949 over a million persons were insured for hospital care. The insurance industry became interested in the field, and by early 1957 more than four million in this province, including 2,250,000 Blue Cross participants, were protected at least in part. The problem of finance, foremost on hospital administrators' 1957 list of headaches, will be approached in 1959 with a sincere effort to help the hospitals to find the money to finance their services.

D. W. Ogilvie

From January 1, 1959, all enrolled residents and all indigents will be covered under the plan, whether in or out of hospital. Any who choose to remain out of the plan will pay the cost of care and treatment when they are hospitalized. The cost of the program for 1959, estimated at 210 million dollars, will be shared by the federal government, the provincial government, and those paying premiums. The plan provides broad coverage at standard ward level in all public general, Red Cross, convalescent and chronic hospitals, and in mental institutions and tuberculosis sanatoria approved by the Commission. There is no restriction on length of stay; medical need is the criterion for both admission and discharge. Emergency out-patient services will be provided immediately following an accident.

The plan will be mandatory for all residents employed in groups of 15 or more, and will be available on a voluntary basis for all other residents. Employers must register their employees by August 31, 1958, while those enrolling voluntarily may register in groups or as individuals up to October 31, 1958. Premiums will be paid monthly by the employed

**Mr. Ogilvie is a commissioner and director of the Hospital Care Insurance Branch of the O.H.S.C.*

groups, and quarterly by others.

Prepayment of three months' coverage by one month's premium will provide a "period of grace" to cushion times of unemployment and financial setback. (See page 42). This incentive to enrollment will apply to both mandatory groups and those who enroll voluntarily.

Wide publicity will be given the rates and benefits of the plan, emphasizing the benefit of the prepaid grace period for those who enroll in 1958, prior to the introduction of the plan. After it has been introduced, employers of mandatory groups will be required to ascertain whether new employees are insured, and if they are not enrolled, to make payroll deductions sufficient to provide the necessary prepayment period. In this way all employees will be covered for three months from the date of their last premium payment even when they change jobs or are temporarily unemployed.

Some people will choose to remain out of the plan when it is introduced. If a waiting period for these individuals were not applied, they might easily avoid paying the premiums until they were on the way to the hospital. To protect the plan from abuse, those who do not enroll in 1958 will be required to wait six months before qualifying for benefits.

Payments to hospitals by the plan on behalf of insured persons will be based on the full cost of providing standard ward care. Full cost will also be paid for all indigent cases—a feature welcomed by hospital boards of trustees and administrators. Under the 1959 program, all Ontario residents receiving categorical assistance, mother's or disabled person's allowance, for instance, will be provided insured status at provincial government expense, and any hospitalization incurred by them will be paid for by the plan at full standard ward cost. Although the number is expected to be fewer, there will still be uninsured residents who are unable to pay their bills. Municipalities, since they alone have the machinery, personnel, and procedures, will continue to determine indigent status. A committee of municipal and welfare officials is currently trying to develop a criterion of indigency which can be applied uniformly throughout the province. Although municipalities will still be required to pay a statutory per diem amount for each indigent case admitted to hospital, in order to encourage them to assist the plan, the provincial government will make an unconditional grant to the municipalities sufficient to off-set the outlay incurred by these statutory payments. Despite the increased number of insured patients and the plan's provision for indigents, there will, of course, still be bills that hospitals find difficult to collect. For this reason, provision is made for plan payment of bad debts of a reasonable amount as one of the costs of operation. Under Bill 320, bad debts are a shareable cost.

Determination of the premium rates to be charged in 1959 was a problem studied intensively for many months by the Commission

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On Hospital Facilities

Rt. Rev. J. G. Fullerton, D.P.,*
Toronto, Ont.

BEFORE discussing what the views of the Commission are on hospital facilities in Ontario it may be interesting to discuss why the Commission should have any views on this matter.

By the Hospital Services Commission Acts of 1956 and 1957 the Commission has been charged with the following responsibilities:

(a) to ensure the development throughout Ontario of a balanced and integrated system of hospitals and related health facilities;

(b) to approve the establishment of new and additional hospital and related health facilities;

(c) to approve the payment of grants for hospital construction and maintenance;

(d) to establish and operate, alone or in co-operation with one or more organizations, institutes and centres for the training of hospital and related personnel;

(e) to conduct surveys and research programs and to obtain statistics for its purposes.

Msgr. J. G. Fullerton

I shall deal with the Commission's view of its responsibilities under the five functions mentioned which are, in essence, summed up in the first, *i.e.*, "The development throughout Ontario of a balanced and integrated system of hospitals and related health facilities". The legislators who framed this Act could scarcely have chosen more suitable language in which to challenge the high ideals, the creative instincts, and administrative abilities of the Commission.

You will note that the word is *development*, not establishment or creation. Development suggests a process of evolution, the use of what now exists, a continual process of growth to something better, a system of hospitals and related health facilities which serve the purpose of providing good health facilities for the people of Ontario. It also suggests that the aims of the Commission shall be accomplished through co-operation and working with others, not by order *(fiat)*, but by agreement.

The words "throughout Ontario" are emphasized. The system envisaged is one which shall serve equally well all parts of the province—the big city, the smaller towns, the rural areas, the highly developed areas, and the frontiers.

Note the word "balanced". This suggests that the facilities offered shall be in proper proportions. There must not be too many active treatment beds and too few beds for the chronically ill. There must be provision for treatment of children as well as for the treatment of the aged. There must be sufficient beds for obstetrics but, at

**Father Fullerton spoke as a commissioner and is now vice-chairman of the Commission.*

the same time, the need for medical, surgical, and psychiatric facilities must not be overlooked.

Notice also, that the facilities must be "integrated". This means that all facilities must be co-ordinated to complement each other. If the best treatment of the patient can be carried out by a short stay in an acute treatment hospital followed by a stay in a convalescent hospital, or in the rehabilitation centre of a hospital for the chronically ill, this is the program to be developed. All the benefits of specialization must be sought, yet the facilities must be so related that the patient can be treated as a whole person. The word "system" indicates organization.

In the final words, "hospital and related health facilities", the legislators have recognized that present forms may not always be considered the best and that the Commission should be free to serve the people of Ontario by developing facilities best suited for patient care under their jurisdiction.

While the powers entrusted to the Commission under this legislation are broad, there was, I am sure, no thought in the minds of the legislators—nor is there in the minds of the commissioners—that we are to infringe on the territory of others who are also concerned with the health and the care of the sick of this province. This outline of the responsibility with which the Commission has been charged should show clearly why the Commission is interested in hospital facilities.

In its short life the Commission has not had time to formulate policies on many matters. However, it has inherited certain legislative directives formerly administered by the Department of Health. It has inherited the experience and wisdom of the Public and Private Hospitals Division of that department; as well as the guidance inherent in a system of capital grants. The Commission has used all these, within the limits of discretion allowed to them, to implement the objectives implicit in their incorporating legislation. It may therefore be helpful to review briefly the present policies and viewpoints of the Commission.

How Many Hospitals Are Needed?

Many different opinions are held on what should be the ratio of hospital beds to population. The Michigan Hospital Survey indicated in 1946 that that state needed 4.86 beds per 1,000 of population.[1] In 1953 Reed and Hollingsworth concluded that in average United States conditions 4.4 to 4.7 hospital beds were needed per 1,000 people for diagnosis and active treatment of general illness, with an additional 2.3 to 2.6 beds per 1,000 for chronic illness and convalescence.[2] Combined bed needs therefore were estimated as between 6.7 and 7.3 hospital beds per 1,000. In 1951 the Saskatchewan Health Survey Committee estimated that 7.5 beds in general hospitals were needed to meet total needs, and, Saskatchewan in experience, has found this to be a fairly accurate estimate.[3]

For some years Ontario, by regulation, has limited aid to general hospitals to projects where the building program did not provide beds in excess of 5.5 per 1,000 of population. Although there has been no definite regulation on the matter it has been accepted policy that hospital beds for the chronically ill would be approved up to 1.5 beds per 1,000 of population served. In estimating populations for purposes of approving construction grants, recognition is made of the fact that Ontario is rapidly growing and ten per cent is added to the latest figures on population. Also, children's beds are not counted in arriving at the figure of 5.5 per 1,000.

During the past ten years in Ontario the ratio of beds per 1,000 of population has increased from 3.95 to 5.35 beds. A survey of the bed ratios in the various districts of the province, together with the bed occupancy rates, indicates that while the figure of 5.5 beds per 1,000 may be the average requirement of the province, there are areas in which this would provide too many beds. There are other areas in which this would hardly be enough. For instance, there are two hospital regions in which the average occupancy of beds is less than 73 per cent, yet the ratio of beds is approximately 3.5 per 1,000. There are two other regions in which beds exceed 6 per 1,000 and yet the average occupancy is 74.3 per cent in one case and 79 per cent in the other. The lack of beds for the chronically ill in the latter region may partly explain this, but in the first of these high capacity regions there are 1.67 beds for the chronically ill per 1,000.

The Commission is particularly interested in helping communities where there is actual need for hospital accommodation to obtain it; and to extend to them any aid which is available in the way of capital grants. It must be pointed out that while it is commendable for communities to wish a hospital within their borders, yet in areas where patients can easily be transported several miles it may not be advisable for each community to have a hospital. Building hospitals too small results in duplication of facilities which might serve a larger number of patients. It is also likely to prevent the development of good hospital service because hospitals cannot afford specialized staff when their volume of work is too small. While the Commission has no power to make two communities get together it will certainly encourage the development of an existing institution if it can reasonably serve the needs of the community rather than the development of duplicate facilities.

The Commission has come to know by experience that, with building costs where they are, the problem of raising sufficient funds in smaller communities has been difficult, often to the point of embarrassment, and many projects have suffered. The premier, on behalf of the government, has therefore insisted that, before final approval is given to any program, firm bids shall have been received, and that funds shall be available not only for the building cost but also for architect's fees, equipment, furnishing, and landscaping. A hospital partly built or not equipped is no hospital at all. I think you will agree that it is sound practice to make sure that every dollar spent shall be effective in producing patient facilities. The experience of the Commission is such that it may be considered wise to insist that, in addition to the above costs, funds should also be provided for working capital. If the project is an entirely new hospital it takes time before revenue begins to come in and also before use of the hospital is worked up to the point where revenue can carry its operation. If it is an addition to the hospital there is generally a disruption in the use of present facilities with a consequent loss of revenue and it also takes time before revenue from the new portion is sufficient to carry its operation.

The Commission is deeply interested in the provision of facilities which will provide for the treatment of the chronically ill. It notes

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For references see page 88

Rates and Benefits

under the Ontario Plan

THE Ontario hospital services program will provide far more comprehensive hospital insurance benefits than are available under Blue Cross or any other private plan. They include the following in-patient services:

- accommodation and meals at the standard or public ward level;
- necessary nursing service, but excluding private duty nursing;
- laboratory, radiological and other diagnostic procedures, including necessary interpretations;
- drugs, biologicals and related preparations as approved under provincial schedule;
- use of operating room, case room and anaesthetic facilities, including necessary equipment and supplies;
- routine surgical supplies;
- use of radiotherapy facilities for treatment of cancer where available;
- use of physiotherapy facilities where available, and other services rendered by persons who receive remuneration for it from the hospital;
- care and treatment in mental and tuberculosis hospitals;
- out-patient services for emergency admissions providing the individuals concerned are received as "out-patients" within 24 hours of an accident.

The Ontario hospital services plan is confined to standard ward care, but by reason of its other broad features, it will cover by far the major part of the non-medical bills of those who require hospitalization. Benefits will be available to everyone paying premiums and to persons in receipt of social assistance payments on a means test basis without limitations:

1. There will be no limitation on a patient's length of stay in a hospital such as is a condition of all existing private plans. Thus, the Ontario plan removes from the patient and his family the responsibility for meeting not only the expense of short-term stays in hospital, but the crippling financial burden of a catastrophic illness involving confinement to hospital.

2. There will be no limitation due to age or occupation. Protection is provided at the same low premium in old age as in youth.

3. There will be no exclusions for pre-existing conditions. Neither a pre-existing nor an existing illness nor the amount of hospital expenses incurred will be a barrier to enrollment or participation in benefits.

4. Benefits will be made available to recognized social assistance cases whose inability to pay has been demonstrated by a means test. The province will pay the premiums for these classes. They include needy persons receiving old age security and assistance payments, blind persons' allowances, mothers' allowances and disabled persons' allowances.

5. The benefits outlined will be available in all the public hospitals and mental institutions, tuberculosis sanatoria and chronic and convalescent hospitals that are approved by the Commission.

6. As patients in mental hospitals and tuberculosis sanatoria will become eligible for benefits, no deductions from old age pensions or old age assistance payments will be made, as is the present practice, providing the premium is paid. The saving to the patient or his family therefore will be considerable.

Eligibility and Mandatory Features

The Ontario hospital insurance program will be available to everyone regardless of age, occupation or condition of health. Except for social assistance cases, the only condition governing eligibility for benefits will be the payment of a monthly or quarterly premium. In social assistance cases, where inability to pay the premium has been established, the province itself will pay the premium. Patients in any public general, chronic, convalescent, mental or tuberculosis hospital may enroll for benefits by paying a premium or by having one paid on his or her behalf.

Enrollment in the program will be compulsory for all employees of firms with 15 or more employees. These mandatory provisions will be extended to include others of the population as the Commission's administrative organization develops. The full benefits of the plan will be available to all others on a voluntary basis at the same rates, and every facility to enroll for benefits will be extended to firms with fewer than 15 employees, to self-employed persons such as farmers, and others.

Firms with 15 or more employees will be required to register all employees on their payrolls by August 1958. The initial premium for such employees will be paid in December 1958, making each such employee eligible for benefits commencing in January 1959. As the installment normally payable to Blue Cross and other insurers will not be paid in that month, there will be no overlapping of premium payments. All premiums for employees shall be remitted monthly to the Hospital Services Commission of Ontario.

To be eligible for benefits without a six-month waiting period, all individuals who are not "compulsory" members—that is to say, with firms of fewer than 15 employees and self-employed and other individuals — must register for coverage and pay one month's premium before October 31, 1958. Subsequent premiums shall be paid on a quarterly basis, commencing in January 1959, with ensuing premiums being payable each quarter.

Individuals who do not enroll prior to the commencement of the program will be obliged to wait a period of six months following the date of their application before becoming eligible for benefits. Such a waiting period is necessary after the program comes into operation to prevent abuses by persons who might otherwise enroll in the program just prior to entering a hospital for treatment. Sound actuarial requirements make it imperative that such practices be prevented. All persons other than recognized social assistance cases or medical indigents who fail to enroll in the program and require to go to hospital will be obliged to pay their own bills.

Prepaid Insurance Benefits

Early enrollment in the program and punctuality in paying premiums will alone safeguard the individual and the family against the hazards of large hospital bills. There is no substitute for promptness and regularity of payments. The program will be operated so that all members will have three months' prepaid insurance follow-

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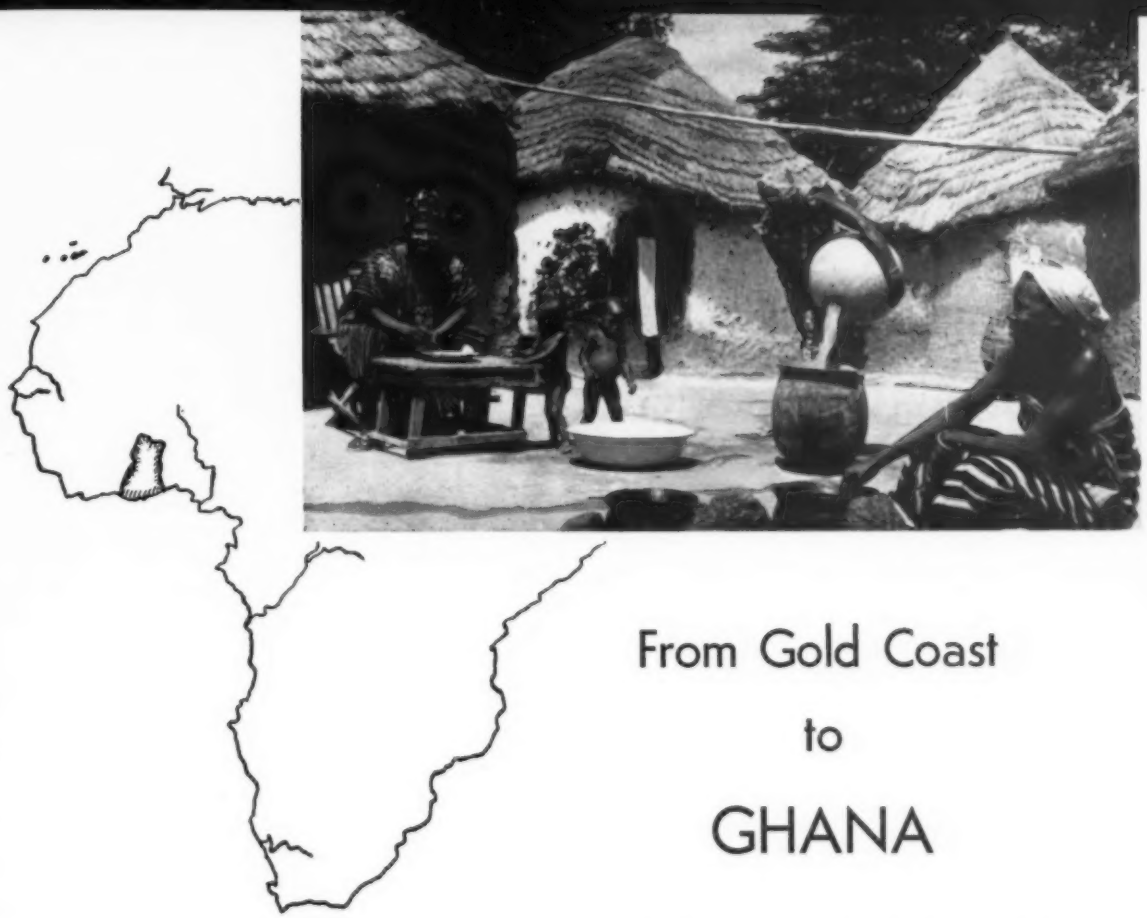
These are the rates and benefits officially announced by the Ontario Hospital Services Commission in October, 1957.



From Gold Coast to GHANA

Achievements of medical services in the war against uncontrolled disease.

HEALTH, and the medical services needed to maintain it, play a vital part in a nation's well-being, standard of living and general achievement. When the Gold Coast set out on March 6, 1957, as an independent nation under the name of Ghana, it did so with a background of great progress in these fields.

Ghana forms part of that West African area justifiably known in former days as the "white man's grave". The indigenous inhabitants appeared in comparison to be immune to the effects of climate and tropical disease, but the appearance was misleading.

The first reason is that little was known of African morbidity and mortality. Second, the healthy Africans who contrasted so sharply with the Europeans were the survivors among a population that encountered the climate and disease at birth; only after repeated infections in infancy did they become immune to the malaria, yellow fever, and enteric that carried off the Europeans. Not much more than half of the African children conceived can have been surviving through birth and childhood to adult life. As adults, except in the most favoured urban areas, they were at the mercy of famine and epidemic diseases.

Town sanitation and the building of urban hospitals are measures that no government could neglect, and the Gold Coast has long been well served with both. The Gold Coast Hospital at Accra, opened 30 years ago, still compares favourably with the majority of African hospitals. The new Central Hospital at Kumasi, built at a cost of £3,000,000 with Colonial Development and Welfare funds, is a truly magnificent building.

District hospitals, of simpler but efficient design, and health centres, make up a network of static medical centres in town and country. They are staffed by locally trained African nurses, whose qualifications, if those of a State Registered Nurse, have since 1950 been recognised as reciprocal with those of the United Kingdom. Medical training, however, must be obtained overseas, and government scholarships are available for the purpose. The first two government medical scholars are now respectively chief medical officer and surgical specialist.

But hospitals treat only those who attend them. To take only one example, midwifery cases are notoriously slow to learn of the advantages of medical attention. Doctors in the Gold Coast Medical Service have never regarded this

This article comes through the courtesy of the United Kingdom Information Service. The author is B. B. Waddy who was for many years in the Gold Coast Medical Service. He is now a senior lecturer at the School of Hygiene and Tropical Medicine in London, England.

The new Central Hospital and Nurses' Training Centre, Kumasi.

with complacency, but have gone out among the poorest and most backward people, overcoming superstition and ignorance by persistence and tact. Nowadays, a domiciliary midwifery service covers most of the country, and the work of certain missions, of which the convent at Jirapa is an outstanding example, must not be forgotten.

In the rural areas, endemic diseases are liable to affect so large a proportion of the population as not to be amenable to hospital treatment; a mobile organization, diagnosing and treating them on the spot, is essential. The first such disease to be tackled was sleeping sickness, which devastated large areas of the northern territories and Ashanti 30 years ago.

By a campaign of mass survey and treatment, carried out village by village, and of tsetse fly eradication, sleeping sickness was controlled within a few years so that it now accounts for only a handful of deaths annually. The sleeping sickness organization was expanded later to form the medical field units, which carry on a general survey of endemic disease in the rural areas, and provide on-the-spot treatment and preventive measures.

Through this organization sleeping sickness is kept under constant surveillance; yaws, the unsightly and crippling condition that can render whole rural communities wretched, is being eliminated; leprosy has been surveyed, case by case, and out-patient treatment with the most modern drugs is available within reasonable walking distance of everyone; schistosomiasis, guineaworm and onchocerciasis (river blindness) have been surveyed, and their treatment and preventive measures initiated.

The crippling effects of yaws and guineaworm, the blindness due to onchocerciasis, or the communal debility following epidemics, may be the cause preventing a primitive agricultural community from dragging itself out of the cycle of bare subsistence and famine. The effects of better health on the community's standard of living can be seen already in some parts formely regarded as the poorest rural areas of the Gold Coast.

The difficult problems of malaria and tuberculosis are investigated by *ad hoc* units each under its own specialist. Besides carrying out their primary objects, the doctors and teams of medical field units, malaria and tuberculosis survey units carry health propaganda into the remotest hamlets.

Epidemic disease no longer presents the old terrifying picture. It is now ten years since the last considerable outbreak of smallpox, and there is not likely to be another. Cerebro-spinal m e n i n g i t i s,

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Maternity and child welfare.

Research worker fishes for Similium flies.

Hospital Accreditation—

"The reward is worth the effort"

J. B. Neilson, M.D.,*

FOR the past two years I have been privileged to be in close contact with hospital accreditation, having been a representative from the American Hospital Association to the Joint Commission on Accreditation of Hospitals as well as a representative from the Canadian Hospital Association to the Canadian Commission on Hospital Accreditation. On the latter body I have had the rather dubious honour of being treasurer—a position which has had a fair share of problems in recent months.

From these contacts it has been obvious to me that the commissioners and officials directing the accreditation program are striving constantly in the cause of the best quality of care for the patients in our hospitals. It is not always easy in these days to resist the force of criticism and the questioning of accepted standards by those who would seek changed or lowered standards. The prestige of the program has been achieved, in large part, by the high standards which have been set and maintained. Hospital accreditation has never been something which is too easy to obtain. I hope it will continue that way.

I have heard rather frequently the criticism that the physicians who represent various medical organizations and who constitute the majority of the membership on both the Canadian and Joint Commissions are attempting to dominate the policies of the Commissions and are even seeking control. My experience strongly refutes this criticism. In fact, at all Commission meetings I have found a sincere and co-operative effort on the part of both medical and hospital representatives to develop and carry forward the best program and, where possible, to promote an ever-better quality of patient care in our hospitals.

The late Dr. Malcolm MacEachern has left behind him many significant and lasting accomplishments in the hospital field. Not the least of these was his pioneering effort in the development of the standards which were originally adopted and promulgated by the American College of Surgeons. It is, I think, worthy of notice that a group of organized surgeons was the first to recognize a need for some type of hospital standards. Under the American College of Surgeons, and with the crusading leadership of Dr. MacEachern, the program grew steadily in scope and importance. Even hospitals in Canada were accepted for survey and accreditation, although no direct financial assistance was provided by Canadian sources.

By 1952 it became apparent that the resources of the American College of Surgeons alone could not carry the program, and the College indicated its intention of abandoning it unless some help could be procured. The proved value of the program (which is now known as "accreditation") was sufficient reason for all concerned to join in carrying it on. At that time a Joint Commission on Hospital Accreditation was formed with headquarters in Chicago. Members represented the American College of Surgeons, the American Hospital Association, and the American Medical Association. All of these organizations agreed to contribute financial support to the accreditation program and each organization was granted a certain number of representatives on the Commission. The Joint Commission, when organized, offered membership to the Canadian Medical Association. This offer was accepted and the Canadian Medical Association now has one representative on the Joint Commission.

Soon after the Joint Commission was formed, considerable discussion began to take place in Canadian medical and hospital circles about ways and means of improving the accreditation program in Canada. Out of these discussions came the proposal for the formation of a Canadian Commission on Hospital Accreditation which would carry forward the accreditation rôle as particularly applicable to hospitals in Canada. This organization, which came into being in 1953, has representation from interested groups which support the organization by yearly contributions as noted in Fig. I.

The Canadian Commission has 12 members who contribute to an annual budget of $30,000 for the Commission. It appoints a chairman and has usually held two meetings each year in Toronto.

The primary purpose of the Canadian Commission has been that of advancing and improving the accreditation program in Canada. In order to do this the Commission has adopted the same standards as those used by the Joint Commission but appoints and employs its own hospital surveyors. The Joint Commission continues to survey

Figure I

Organization	Number of Representatives on the Commission	Yearly Contribution
Canadian Hospital Association	5	$12,500
Canadian Medical Association	4	$10,000
Royal College of Physicians and Surgeons of Canada	2	$ 5,000
L'Association des Médecins de langue française du Canada	1	$ 2,500
Total	12	$30,000

**Dr. Neilson gave this paper at the Ontario Hospital Association's convention in October, 1957. He was then superintendent of the Hamilton General Hospitals, Hamilton, Ont.* *See page 12.*

hospitals in Canada using surveyors appointed through the American Hospital Association. To give some indication of the activity of the Canadian Commission a few figures may be of interest. In the year 1957 it was planned that 146 hospitals would be surveyed in Canada. Of these, 102 would be surveyed by surveyors working for the Canadian Commission, the remaining 44 would be surveyed by Joint Commission surveyors.*

Under the existing arrangement, allocation of surveys in Canadian hospitals is made by the Joint Commission since, at the present time, this is the only recognized accreditation body. Therefore all survey reports are forwarded to the Joint Commission; results of surveys are reported and certificates are issued by that body.

At the inception of the Canadian Commission it was our good fortune to procure the services of Dr. K. E. Hollis of Toronto as director. Much of the growth of the Commission, both in reputation and activity, has been due to his outstanding work. During the past few months it has been necessary for Dr. Hollis to curtail his work and he has relinquished his appointment as director, but continues as a surveyor. We have been fortunate in pursuading Dr. W. I. Taylor, formerly of Peterborough, to take over as director. He assumed the appointment on September 1, 1957 in a full-time capacity and we are quite confident that he will continue the strong leadership required by the Commission and its program.

With the growth of the Canadian Commission, and the evidence that it could serve the needs of Canadian hospitals, came the conviction that an accreditation program using only Canadian resources was a feasible undertaking. Approval of an all-Canadian program was given previously by the other participating organizations and, at its biennial convention in May 1957, the Canadian Hospital Association also went on record as favouring an all-Canadian program.

The decision has, therefore, been reached to proceed with plans for the commencement of the all-Canadian program on January 1, 1959 and the Commission is facing the prospect with enthusiasm. Although many reasons have been advanced for continued association with the Joint Commission and although the all-Canadian program has not met with unanimous approval, it seems to be an inevitable development which can, in the opinion of the commissioners, be faced by 1959.

Some two years of actual experience in conducting surveys of Canadian hospitals, by Canadian surveyors, has given a pretty accurate picture of the finances required to run the program now and for the next three years at least. The Commission feels that with continued support by the constituent organizations at the present level, and with some funds now available in the form of a small surplus, a satisfactory all-Canadian program can be operated for the years 1959 and 1960 without any call for additional contributions from the constituent organizations. Personally, I am confident that this can be done.

Remunerating Surveyors

One of the very real problems in operating an accreditation program in Canada is the cost of the travelling involved in serving the hospitals across the country. The Commission has given serious and continued consideration to travelling expenses and to various ways of handling the job. The result has been the recent development of a new method of remuneration to the surveyors. Surveyors are to be paid a specified sum for survey of a hospital, the sum being dependent on the size of the hospital. This is a much better plan than the payment of salary, and permits engagement of surveyors in various parts of Canada to survey hospitals close to their own areas, thus decreasing the outlay required for travelling expenses. Limited experience with this method has been quite successful and our feeling is that the adoption of the method will go a long way towards meeting the requirements for hospital surveyors and help solve one of the Commission's financial problems.

Dr. J. B. Neilson

Size of the Task

As of January 1957 there were in Canada 682 general hospitals and tuberculosis sanatoria having more than 25 beds and thus eligible for survey. Of this number, 351 or 51 per cent had been visited by surveyors and 292 hospitals or 43 per cent had been rated. The program has had its greatest popularity in the Maritimes where approximately 70 per cent of the hospitals have been surveyed. It is apparent that the program still has a long way to go if the ultimate object of accrediting every eligible hospital in Canada is to be achieved. It has been estimated that for the next three years the number of initial and repeat surveys to be done in Canada will be about 130 annually and probably 20 a year will be initial surveys. The Canadian Commission should be able to handle this volume of work by January 1959.

In the province of Ontario, as of this date, there are 178 hospitals eligible for accreditation. Of this number 96 hospitals or 56 per cent have been surveyed, of which 80 are fully approved, 6 are provisionally approved and 10 are not approved. During 1957 it was planned that 17 hospitals in Ontario would be surveyed.

I think we must agree that in our province, where only 56 per cent of our eligible hospitals have been surveyed, we cannot be too proud of our showing. It might, therefore, be worthwhile to look at some of the reasons for this and to consider what might be done to improve the situation.

There must be very few people in the hospital field who do not feel that accreditation is a worthy objective for any hospital. It should be true that with the amount of publicity given to accreditation, anybody wanting printed information on the requirements for accreditation knows where to get it. The Canadian Commission on Hospital Accreditation at 150 St. George Street, Toronto, will provide this information and will be

Actual surveys in 1957 by Canadian Commission—104; by Joint Commission—46; total—150.

happy to assist any hospital requesting help.

If accreditation is a desirable thing then somebody in the hospital has to translate the desire into action. In most instances it is the administrator who gets things under way, but in many hospitals the medical staff or even the trustees have been the initial moving force. The Commission is attempting to publicize accreditation as widely as possible, this publicity being directed primarily to the administrator, the medical staff, and the trustees. We are encouraged by the increasing interest in accreditation, particularly by hospital governing boards and medical staffs, and I do not think I can describe the situation better than to quote from Dr. Hollis' report to the Commission in January 1957:

"I think encouragement is to be derived from the greater interest in our program, shown all across the country, by hospital governing boards and medical staffs. Everywhere, the doctors want to meet the representative and discuss with him their problems and deficiencies. These doctors appreciate the policy of the Commission in encouraging your representatives to take time to meet them. The policy is paying off and our program, sometimes looked upon as a lot of red tape and annoying requirements, is being accepted as sound organization and good practice. At a meeting of a medical staff, in a district that admits to great progress during the past two years, a speaker, in acknowledging my remarks said, 'One of the greatest factors in establishing c o-o p e r a t i o n and friendly relations among our staff members has been the implementing of the requirements for full accreditation' ".

It has always been the policy of the Commission to try to assist hospitals with their accreditation problems. However, for obvious reasons, it is not possible to have a surveyor visit hospitals that are merely thinking about accreditation. There are just not enough monies or surveyors to carry on a program of "dry runs". The Commission will do all it can to answer written enquiries and the director is prepared to meet hospital representatives by appointment in his office.

When formal application has been received, and the surveyor visits the hospital, he expects to, and wants to, meet members of the board of trustees and medical staff, and he will welcome the opportunity of discussing accreditation problems with them. Hospital surveyors have indicated that they can sense pretty quickly the measure of enthusiasm a hospital has for accreditation by the reception they receive. Some surveyors have told me that they have visited hospitals which gave them no opportunity to meet members of the medical staff or board of trustees. The surveyor's reaction, of course, would be rather obvious since the accreditation of a hospital requires evidence of co-operative effort on the part of administration and medical staff.

One of the very real difficulties in quite a number of our hospitals these days is the overcrowding in the patient and service areas. In many instances it has been necessary for the surveyor to recommend non-approval or provisional approval because of this overcrowding. I think it must be agreed that it is not possible to give good quality care where patients are distributed in corridors, sunrooms, et cetera. Hospital administrators should make it their responsibility to keep abreast of the hospital needs in their community and do everything in their power to ensure that adequate facilities are provided.

In carrying out a survey the primary concern of the surveyor is an assessment of the quality of patient care in the hospital. It is not possible for him to judge the quality of care by being present on the wards or in the operating theatres to see what is being done and how well it is being done. His assessment of the quality of care must necessarily be made from study of the patient records in the hospital. All of us in the hospital field are very much aware of the difficulty we have in pursuading physicians to provide a suitable record of the diagnostic work-up and of the treatment given to the patient during the illness. Physicians, like o t h e r people, resent having to handle mounting piles of "paper work". The physician is particularly vulnerable because he is involved in a seemingly interminable round of forms and statements — all of which urgently require completion. In the hospital it is not an easy task to sit down and write a long record, especially when he has seen the patient before in his office and has a record there.

If we are to have good, or maybe I should say acceptable, records it is very important that we give serious thought to all the possible means of procuring them. Each hospital should, therefore, examine its own problem and attempt by practical methods to make it easier for the physician to prepare and complete his record of the patient. In quite a few hospitals records have been improved by using methods which are simpler than the handwriting of histories, diagnoses, progress notes, et cetera. One method which has great possibilities is the provision of dictating equipment so that the physician does not have to write out the record. Other hospitals have made medical stenographers available for the operating room or other areas.

A good record does not need to be voluminous. It should, of course, provide the pertinent data but negative information is not necessary. Much can be done to improve the quality of medical records by the provision of suitable history forms which encourages the recording of essential information with the minimum amount of writing. Check-type history forms have a limited, but valuable place here.

Once the medical record is completed it goes into the custody of the medical records department of the hospital. Checking for completeness, coding and filing records, and the extraction of various types of statistical information is the function of the records department. The information to be made available to tissue committees and for medical audit purposes comes mostly from this department. It is therefore important that the hospital do everying it can to establish a records department able to produce the information required for accreditation purposes. The best way to do this is to have the department under the charge of a trained medical librarian with trained assistants.I am quite aware that there is a shortage of trained record librarians and that they are not now available in the numbers required by hospitals. However, every hospital should attempt to procure the best trained person they can to head up this important department.

The Canadian Hospital Association through its training program for records librarians is helping to meet the shortage. The association is trying to expand its program and is endeavouring to interest more hospitals in making

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M.H.A. Finance Institute

Control Through Accounting

WITH some 130 hospital representatives in attendance, a very well-planned institute on hospital accounting and finance was conducted by the Maritime Hospital Association in Moncton, N.B., December 4 to 7, 1957. The program was under the direction of Walter W. B. Dick, C.A. All four days were of interest to accountants, but the program of the third day dealt with administrative aspects of financial control and was attended by a number of administrators not registered for the full institute. Similarly, on the final day, the topics presented were of special interest to the trustees and advisory board members who attended for that day only.

The mechanics of accounting and the application of the *Canadian Hospital Accounting Manual* received close attention on the first two days of the institute. In addition to Walter Dick, speakers included Medard Collette, Peter M. Stevens, George H. Steeves, and James O. Borlase of Hudson, McMackin & Company, Moncton; and from the same firm in Saint John came G. Andrew Oulton and Irvine E. Millie. Presentations during this technical part were also made by Richard R. Rice, Moncton Hospital; P. Maurice Blanchet, Saint John General Hospital; and Murray W. Ross of the Canadian Hospital Association. Bookkeeping and accounting techniques, using manual and machine posting methods, were explained by representatives of equipment and systems manufacturers. These included George Nolan, Moncton, N.B.; J. W. Rogerson, Toronto, Ont.; and A. H. Thomas, S. R. Romans, and J. D. Miller of Saint John, N.B.

Rev. Mother Saint Georges, provincial bursar of Les Religieuses Hospitalières de Saint-Joseph, introduced the subject of budgets. George Steeves gave a practical review of the mechanics of preparing budgets; and Charles W. Campbell of the comptroller general's office, Fredericton, N.B., discussed budgets as a basis for reimbursement under government-sponsored hospital insurance. E. Hampton Decker, administrator of the Springfield Hospital in Springfield, Mass., spoke on hospital rate setting and how to use financial statements. Ruth Wilson, Moncton, executive director of the Maritime Hospital Services Association talked on Blue Cross as a voluntary method of financing hospital care for patients. Rupert Stocker, administrator of Victoria Public Hospital, Fredericton, discussed what the administrator expects from the accountant; and he subsequently presided over a panel consisting of Mother Saint Georges, Ruth Wilson, and Dr. A. M. Clark, executive director of the Moncton Hospital.

"The what, why and how of depreciation" was a topic very ably handled by George W. Hudson of Hudson, McMackin & Company, Moncton. (This and a number of other papers presented at the institute will appear in future issues of this journal). Dr. H. F. McKay, New Glasgow, N.S., president of the Maritime Hospital Association, spoke on hospital problems of today and tomorrow, emphasizing the necessity of using the year ahead to streamline accounting and financial control, budgeting practices, et cetera, in preparation for the coming of hospital insurance. Dr. D. F. W. Porter, Vallée-Lourdes, N.B., president of the Canadian Hospital Association told of the responsibilities of hospital trustees and advisory boards for hospital financial policies.

Rev. Mother Berthe Dorais, Montreal, Que., treasurer-general of the Sisters of Charity (Grey Nuns), presented an excellent paper entitled "Whither Hospital Finance, Administration, and Control under a Government Hospital Care Plan?" She then presided over a panel consisting of Sister Catherine Gerard, Halifax, N.S., Dr. D. F. W. Porter, and Dr. H. F. McKay. Dr. Joseph A. MacDougall of Saint John, N.B., chairman of the board of trustees of the Maritime Hospital Services Association, quoted liberally from the writings of Dr. E. M. Bluestone in telling the Blue Cross story.

With the emphasis on financial control, the need to maintain a high quality of hospital care was not overlooked, as this subject was discussed by Dr. R. C. Dickson, professor of medicine at Dalhousie University, Halifax, N.S.

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With the Red Cross in Vienna

by Helen Goodrow, B.H.Sc.
Cornwall, Ont.

JUST over a year ago news of the Hungarian revolution electrified the world. I read about it; but, as is too often the case, unless some world event has some personal meaning, it seems rather remote. So it seemed to me until December 8, 1956. On that date—a Saturday morning—the Canadian Red Cross was asked to send a team of seven to look after a refugee camp in Austria, along with the national organizations of the League of Red Cross Societies from 28 other countries. The teams were to be in Vienna by December 12. Up to this point, during November and part of December, the Austrian government had attempted to cope with the situation; but now they realized that they alone could not manage the large number of refugees. It should be remembered that Austria, a self-governing republic, had been occupied by the four powers until 1955, and were in the throes of beginning to rebuild their economy and their country.

By Monday evening, December 10, five of the team were ready to leave. Of that five, four had been asked and had accepted within the first 24 hours of hearing from the Red Cross. Monday had been spent in being measured for uniforms, which incidentally, were ready at six p.m. that same day, cleaning our desks after getting leave of absence for a period of three to six months, and saying quick good-byes to our startled families. Our camp operated exactly six months.

A team leader, an administrative assistant, a nurse and a recreation welfare specialist, a food specialist, a doctor, and a clothing specialist, made up our team which arrived in Vienna on schedule. We were greeted by the Canadian ambassador to Austria, Mr. MacDonald, and his wife; as well as Red Cross officials. In Vienna we were briefed at the League's headquarters, but in this emergency most of the headquarters staff had only been there a short time. They told us as much as they could. Our camp was to be in Wiener Neustadt—about 25 miles southeast of Vienna and about 15 miles from the Hungarian border. Wiener Neustadt had been, before the war, a very important Austrian city—the seat of the Military Academy as well as a cultural centre. After Hitler's *Anschluss* in 1938 it had become the site of a Messerschmidt factory and proving ground, and was reported to be the most heavily bombed city in Austria. There was still much evidence of damage and the population had been reduced from a pre-war 70,000 to 36,000.

Our camp site was the former artillery barracks. It had been heavily bombed, and what we thought, when we arrived at the snow-covered site, were six buildings left out of ten or twelve, were really six out of about twenty-five. The buildings that we used were all solid concrete, very thick and well insulated to keep in the cold! Small coal stoves supplied the only heat. We had an administrative building where the offices of the *Laigerliter*, or the Austrian camp leader, were located, as well as those of the Red Cross team leader, the administrative assistant, the clothing specialist, and part of the stores. Also included was a *Kino* or Cinema Hall where the recreation director had her office. The building was used for movies, English classes, church services, concerts and for two months, the dining room. A very busy spot!

In another building, which we called the hospital, or medical centre, the doctor and nurse had an office. In here too, were a diet kitchen and sick quarters. Two large barrack blocks housed the refugees in rooms that would accommodate from 4 to 30 or 40 (mostly the latter). In all, we accommodated nearly 1,000 people. Then there was the kitchen building, which many years back had been erected as a stable in front and a storeroom, we guessed, in the rear. The regular kitchen had been one of the bomb casualties. The storeroom part we took over as the kitchen and eventually used the former stable for a dining room. The kitchen equipment consisted of three coal-fired kettles, a pair of small sinks, and two stoves, a little larger than home size. The hot water was supplied from the stoves.

It was primitive and rough, a little the worse for wear, but we decided that with soap and water, paint, and willing workers, we would do what we could to make it as livable as possible.

Our camp was used as a transient camp for future Canadians and so, in effect, it became a small part of Canada. I think we felt a certain responsibility in that regard, since we were the first Canadians most of the refugees had ever known. However, one thing we did not attempt was to introduce Canadian dishes. It had been decided that that could come later.

When we arrived, all the refugees were accustomed to taking their food back to their quarters after lining up for it at a single window in the large, cold section that was part of the kitchen building. It was piled high with wrapping papers and boxes, the walls were dirty from disuse. Our first thought was to try to eliminate this system, but lack of space presented a problem. We decided to serve the food in the Kino Hall, about 100 yards away, and set as our goal for this big move the Friday following our arrival in camp. That day had been scheduled as the Toronto *Telegram* Christmas party. We purchased three insulated pots and carried the food in these, along with one large soup pot that was emptied fast enough to keep the soup hot. We were feeding

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This paper was presented at the dietetic section at the Ontario Hospital Association Convention, October, 1957. Another article entitled "Mission-Austria", appeared in the Journal of the Canadian Dietetic Association in November, 1957. Miss Goodrow is with the Canada Bread Co., in Cornwall, Ont.

Food Service

sponsored by the

Canadian Dietetic Association

approximately 1,000 people three times a day so this meant a great deal of hauling to and fro. We first made a "deal"—in exchange for some swill we would be given a hand truck, which was rather antique. Then, when the snow became heavier, that was exchanged for a sleigh; but when the mud came, it was necessary to carry the food by hand. Tables and benches were set up, and the food was dispensed from a plain wooden table.

The nucleus of a kitchen staff had been there prior to our arrival, and the kitchen was operating with a woman chief cook who was devotion itself. Katy continued for our first week or so, writing the menu, then, for the next few weeks we got together with the interpreter. I knew no German and, therefore, couldn't write even a simple soup-meat-vegetables plan that the staff could understand. Can you imagine my sense of achievement when I was able to write the complete menu!

The language barrier was our greatest problem, I think. Without means of communication one can feel very inadequate, rather stupid, and many times completely non-effective.

Our first instruction sheet was given to us shortly after our arrival. It was a ration sheet, and I still don't know where it was originally made up. It listed the rations we could draw and I was completely bewildered by it at first. It included flour, meat, fat, lentils, sugar, rice, cheese, and dry milk. I couldn't imagine making a menu for one day with such a list, let alone figure one for a week or a month, no matter what nationality it was for.

It stated that it was a basic diet for supplying 2,658 calories, and we were to draw a month's rations from it. An appended foot-note stated that the total ration of flour included enough to cover the cost of baking it into bread. The bakery representative told us that it was usual to figure on the following basis: 1 kg. bread=75% flour; 1 kg. bread costs 1 schilling, 67 groschen, to make. The flour price was 367 sch. 95 groshen per 100 kg. but if white flour was received and black bread was supplied, the difference would be 171 sch. and 35 groshen per 100 kg. If we wanted rolls which weighed two decagrams each, we would have to figure them as white bread. It was a bit confusing at first, and the first statement needed quite some figuring to know what was what. Finally, even when we were later allowed to buy a pastry twice a week, we got quite expert at it.

To return to the ration supply—like most basic rations, fresh milk for children, some fresh vegetables and condiments were allowed. Then the rations were soon supplemented with donations from all over the world—and I mean *all* over the world. And I must say that they were gratefully received and put to good use. These often made the difference between the very basic meal and that "little extra" that satisfies.

I was very fortunate with interpreters. At first I tried to get one of the Hungarians who spoke some English to assist. They were fine as long as they stayed, but often they would be in camp for only two to five days. After having two of these "interpreters" leave within a short space of time, it was decided I needed someone of a more permanent nature who would be able to help with stores, books, et cetera. Out of the blue came Mr. Godfrey. He was an Austrian who had left Austria when Hitler came, and had fled to England. He had some experience in kitchens too; and was a former engineer who, like the fabled Mr. Belvedere, could do most anything—cook, fix a tap, do carpentry, and type. He was sixty-two and provided support for the whole team. Unfortunately, he was not able to work beyond two months, but he got me over the worst period of adjustments and re-doing.

I have already mentioned our Christmas party which took place seven days after our arrival. Since we had little time to prepare and knew nothing of a typical Christmas dinner in Hungary, the Hungarian interpreter gathered together a committee fairly representative of the camp's population to plan a menu. They decided upon soup, wiener schnitzel, canned peas, rice (they would have preferred potatoes, but the kitchen staff couldn't manage), large dill pickles, a torte (a many-layered iced cake), and bananas. Of course, the food was only a small part of the party. The recreation director, Olive Zeron, went into Vienna and with the aid of the assistant Austrian camp leader brought 1,000 gifts—small ones, yes — but all bought in one day, and quite a varied selection.

That was the night we heard the Hungarian national anthem for the first time. Imagine with me, if you can, a large gathering of people who had fled from their loved ones, their people, their country. They were facing a future of hope, but uncertainty, and as they sang, I'm sure memories of happier Christmases and of happier days flooded back. The women sang with tears running down their faces—so did many of the men, too; and there was not one of our team who didn't feel a tremor, not run, but creep up our spine. Afterwards we exchanged our thoughts of that moment. Almost without exception they were, "Suppose we were refugees taking shelter in a foreign country, unable to speak the language and never more, perhaps, to set foot in Canada!" However, we did have a happy time over Christmas. Christmas eve we had a concert of camp talent, and a very good one it was! On Christmas day there were church services and a few "extras" for meals.

Our regular meals held a fairly set pattern as there were some limitations to our food and equipment. Each person on arrival at camp was issued with a cup, a soup plate and knife, fork and spoon, so we couldn't have too many courses at each meal.

Breakfast consisted of tea, coffee, or cocoa with one roll and as much bread as wanted, with a pat of margarine or jam. Dinner meant soup, meat, potatoes, or a substitute, sometimes coleslaw or tomato sauce, or sauerkraut, or pickled beets. Freshly boiled vegetables were almost impossible because of our kettle facilities, so we tried to incorporate fresh vegetables in the soup. Bread and, twice a week from February on, a small pastry was added to the menu. Another variation of dinner that some of the Hungarians, I understand, are accustomed to (and it seemed quite popular with them) included very thick soup made with meat and vegetables, and for the main course, noodles topped with ground poppy seed and sugar. It was not popular with the Canadians at all. Supper varied somewhat. One day it might be sardines with bread and margarine, and tea with lemon, or spaghetti and tomato sauce with bread, or milk rice (which they didn't like very much but it helped to sprinkle cocoa mixed with sugar over it). Our issue of cheese was the pasteurized variety we're used to in Canada. But because it was not a familiar food to them, the butch-

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Saskatchewan Consulting Service

TEAMWORK IN ACTION

Irial Gogan, M.B., B.Ch.,
Calgary, Alta.

ANY organization concerned with insuring the health of large numbers of the public has a duty to ensure that their beneficiaries receive not only a volume, but also a high quality of patient care. It is not too difficult to be certain that the beneficiaries of the Saskatchewan Hospital Services Plan receive a great volume of patient care, as we have only to look at the rising costs of operation both of individual hospitals and of the various hospital and insurance plans throughout the country to realize that there is an ever increasing demand for medical and hospital insurance. Before too much time has elapsed, we can be sure that most of the country, if not all of it, will be covered by some form or other of general hospital insurance. We can be sure, also, that the utilization of our hospitals and other health facilities will increase considerably because of the increasing volume of prepayment. The responsibility for ensuring a high quality of patient care does not rest solely with the voluntary and provincially operated insurance plans. This is the individual responsibility of every hospital and of every person who works in, or is associated with, a hospital.

In Saskatchewan, one of the elements which we feel is producing an increasingly high standard of patient care is the consulting service which is operated by the Division of Hosiptal Administration and Standards of the Department of Public Health.

We know that other provinces are very likely to follow the example of this province, not only in providing a prepaid hospital insurance plan, but also in providing a hospital consulting service.

Just over a year ago, it was decided to reorganize the Division of Hospital Administration and Standards, using the team idea which has been so successful in other types of medical organization. We have a serious problem in this province as far as our hospitals are concerned, because of the large number of small hospitals scattered over large distances. (Out of a total of 150 general hospitals, 128 are under 50 beds in size.) We felt that the team approach might be the answer. The province was divided into two areas; two professional teams were organized and headed by hospital administration consultants, both graduates of the hospital administration course of the University of Toronto. Each of these consultants has on his team an x-ray technician, a laboratory technologist, a fully qualified dietitian, a nurse, and an accountant. They also have available to them for consultation purposes, or for direct service, a medical social service consultant, a pharmacist consultant, and a health educator.

These services are available either on an individual basis with members of the team operating singly, or on the team principle, with the members functioning as a group, giving concentrated service to any hospital asking for it or needing it. Our experience with this team concept during the past year leads us to believe that this is a pattern which can be followed by other groups interested in establishing consulting services to their hospitals, whether or not a prepayment organization exists, and whether it is run by the Department of Public Health as it is in this province, by a hospital commission, or by a private insurance organization.

During the past few years we have tried to reduce our "routine" visits to hospitals to a minimum, and our consultants and counsellors now visit usually, at the direct invitation of a hospital, for a specific purpose. They are also frequently directed at regular team meetings by one another's visits to hospitals to areas requiring assistance within their own specialities.

This teamwork, we feel also, is of particular importance in the construction of new hospitals, as each member of the team comments on the sketch plans of any new construction project as they apply to his own specialty. In this way, we hope to eliminate the problems which frequently used to confront new hosiptals *after* they had completed an expensive construction job. To summarize our entire activities would be rather difficult in the space at my disposal, but our work is mainly divided into three phases; firstly, in our direct visits to hospitals, secondly, in the holding of institutes, and thirdly, in our publications.

The visits of our consultants to hospitals take many forms. They may attend a board meeting where advice will be given by the appropriate team member on construction problems or staff management problems. Perhaps the x-ray counsellors will advise about radiation hazards or on the purchase of x-ray equipment. Our hospital administration consultants have been doing a very fine job in encouraging boards to adopt good by-laws both for themselves and for their medical staffs.

There may be advice for the administrator or the accountant of a hospital. Our larger hospitals are starting to use cost analysis and are constantly improving their accounting procedures. This Division had the task of interpreting to the hospitals the new revision of the Canadian Hospital Accounting

This article was written while Dr. Gogan was director of Hospital Administration and Standards, Regina. He is now medical director of Holy Cross Hospital in Calgary.

Manual 1957. This was done through personal visits of accountants and by institutes, in which the hospitals themselves were invited to participate.

Our nurses may visit the matron or superintendent of nursing and advise them on problems, such as the provision of better nursery and obstetrical equipment. Perhaps the hospital may have a cross-infection problem, or there may be the staff allocation problems which confront every hospital.

Our laboratory and x-ray technologists visit the departments directly, continue an in-service training program, and give on-the-job counselling in technical matters, and on-the-job training where needed. Incidentally, our laboratory and x-ray counsellors have trained 51 combined laboratory and x-ray technicians since 1953, in a special course run by the Division. Twenty-seven of those are still working as combined technicians, while 15 have completed their training and have proceeded to the full qualification as registered technicians. Even the unqualified person is given on-the-job training by our technologists during these visits. Our laboratory consultants have recently done a very fine job in encouraging standardized reporting by the hospitals, based on the unit system. The title "inspector" has been completely banished from our Division.

The problems of our consultants are great. They each cover a group of hospitals, having approximately 3,000 beds in each group. This number of hospital beds is spread over a large geographical area, and, indeed, a great deal of time is spent in travelling. In a more densely populated area, it is quite likely that our team of consultants could give their services to a much greater number of hospital beds in fewer hospitals. However, despite the difficulties of weather and distance encountered in this province, our consulting service has become very acceptable to the hospitals, and the calls on the consultants' time are constantly increasing.

Through the work of our consultants we are gradually overcoming the feeling of isolation which often affects the hospital administrator or the superintendent of nursing, or the x-ray or laboratory technician in our smaller hospitals. We know that they appreciate that, by lifting the phone or by writing a note, they are very quickly in touch with an understanding and sympathetic expert in their own field. The fear of the hospitals of "government inspection" is being replaced by the realization that our teams are giving sincere and impartial consultation to the hospitals.

We know their efforts are being successful from the reports we receive of the improved quality of x-rays, the improved quality and number of laboratory procedures, the reduction in the number of cases of cross-infection in our hospitals, and even in the rapid approximation to federal standards of the numbers of beds set up in the province. It is not too long ago since our hospitals housed nearly 30 per cent more beds than their federal rating warranted. This differential is nearly negligible nowadays.

Regional Councils

In addition, the formation of regional hospital councils is a

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Administration Students on Field Trip

On a field trip to the Workmen's Compensation Board, Ontario Branch, recently were students of the years 1957-1959 in the Hospital Administration course at the University of Toronto's School of Hygiene.

Back row, left to right: Robert L. Innes of Toronto, Ont.; Carl A. Meilicke of Prince Albert, Sask.; John W. Barr, M.D., Lanark, Ont.; J. Franklin Rafuse, Lunenburg Co., N.S.; Jim McCleary of the W.C.B.; George F. McCracken, Toronto, Ont.; William S. Hacon, M.B.B.S., Barrie, Ont.; Peter R. Carruthers, Toronto, Ont.; and A. B. McCartney of the W.C.B. Front row, left to right: Eugenia Stuart, professor of Hospital Administration, U. of T.; Sister Mary Martin, Antigonish, N.S.; Dorothy W. White, Rochester, N.Y.; and Sister Mary Loyola, Antigonish, N.S.

In-service education—

"the working-together spirit"

Sister Mary James, SCIC,
Vancouver, B.C.

OFTEN the administrator is asked to speak to various groups within the hospital as well as outside it. People ask this either for the purpose of being enlightened, to receive help in some project—or in order that *they* may be better prepared to further the work of the hospital.

Perhaps the administrator whom you see leaning back in his chair, gazing out the window, is busy thinking. In this particular case, representatives of the nursing department supervisors have just come with a request that he speak to them on "Interdepartmental Relations". At a recent institute one of the main topics was the importance and implication of communications within the hospital organization, and here, he realizes, is an opportunity to put what he has just reviewed into practice. "Our director of nursing was with them," he muses, "I'll ask her for suggestions. It's encouraging to have this request come from them —it shows that our personnel wish to develop the 'working together' spirit . . . And now to work."

The following is the result of some days' effort on the part of the administrator (between interruptions, of course); the suggestions and criticism of his assistant administrator were as helpful and constructive as he had hoped; his thoughts were neatly arranged in type by a competent, enthusiastic secretary. He wisely kept in mind the advice of Percy Ward: "Get up and say something, the best you can—someone else then will be encouraged to stand and say something wiser!" It is hoped that you, the reader, will find the outline he developed helpful.

In Advance

Knowing the value of visual illustrations, the administrator had, in advance, drawn an organization chart of the nursing department on the blackboard. Before his introductory remarks he also distributed copies of a functional chart which showed the relationship between all hospital departments.

On His Feet

Administrator: Interdepartmental relations implies human relations—every word uttered, every act, however slight, performed in the presence of anyone else— each initiates or is part of a chain reaction, the consequences of which are to some extent determined by you.

Any enterprise, to be successful, needs a unity of purpose and direction. Thousands of years ago mankind learned the value of co-operation; we see in our study of the history of nursing how it was found that a definite plan of organization and group action was needed if nursing was to receive proper recognition as an art, and as a profession which required a solid educational and training foundation. In nursing service we see the same need for unity of purpose and co-ordination of effort. The aim of modern nursing care is the care of the patient from the threshold of the hospital when he is admitted sick and insecure, to his cure and return home to family and occupation. Few in the hospital know the whole patient as the nurse does. That is why her most important function is to adapt the hospital and all in it to the cure and restoration of the patient, as far as lies within human power. She has her own sphere of skills, but she needs others to help her. Teamwork, flexibility, and spontaneous co-operation are very important in attaining this objective. In our efforts we should concentrate on co-operation rather than on competition, on team accomplishment rather than on individual achievement.

Let us now look at the organization chart of the nursing department, and see who is responsible to whom, for what, to what extent, and in what area.

Use of Charts

When he had discussed the organization of the nursing department the administrator turned to the blackboard. Level by level he developed the organization chart of the entire hospital.

First he defined the lines of authority, the areas of responsibility, and the relationship of each department to the other in attaining the highest standard of patient care and service. He realized how important it is to draw attention to both the particular objectives of the hospital for its nursing service and nursing education, and to the policies of the hospital which affect the medical staff, patient care and service, and personnel. Only by basing their activities on these policies, he pointed out, can the nursing staff maintain the standards of the hospital.

The administrator then illustrated the three-fold classification of duties suggested by the Kellogg Research Project Institute, 1950, and shown on the functional chart distributed at the beginning of the conference. This classification differentiates:

(1) the institutional services necessary for the operation of the hospital. Purchasing, finance, laundry, housekeeping, personnel, maintenance and engineering, messenger and telephone service, and record departments are common to any institution or industry.

(2) the hospital auxiliary-services peculiar to hospitals and not found in non-health organizations—admissions, x-ray, laboratory, surgery, hospital aides, pharmacy, sterile supplies, medical records, and highly specialized equipment. These are more closely related to patient care.

(3) the professional services provided by the doctors, nurses, dietitians, special therapists, and social workers who are responsible for the direct professional care of the patient.

Administrator: Each of these services, professional and non-

Sister Mary James is assistant administrator of St. Vincent's Hospital, Vancouver, B.C.

professional, is essential to adequate patient care—if any one of them is lacking or functioning independently of the others, the purpose of the group is defeated. Every team, whether it be a football team, or a hospital staff, requires good leadership, but the winning of the game, in the final reckoning, depends on the co-ordination of skills and unity of effort by the players themselves.

Co-operation

Co-operation is the means by which good interdepartmental relations are fostered and developed. This involves an understanding on the part of all of the needs and problems of others.

Within the department it means respect for the authority of the department head and confidence in her knowledge and ability. The nursing supervisor acts in the name of the director of nursing should personnel wish to see her for either a personal or professional reason. It means the application of the team concept to nursing care, even though the members of these teams may vary in different institutions. And essentially it means a definite understanding by each of what is expected of her or him, how much is expected, and when, and the willing acceptance of full responsibility for the accomplishment and correlation of their duties with those of others in the department.

The why of all this is vital. Theory is important, but theory-plus-experience is invaluable.

There must also be co-operation with all other departments in order to reach the high quality of patient care and service which is their common goal. Misunderstandings and ignorance are the basis of 90 per cent of the awkward relations and clashes which sometimes occur between departments. A general knowledge, at least, of the why and how of the activities of other departments, to the extent that they effect nursing service, can be the greatest link between the different departments. One example of an honest misunderstanding:

A little girl came up to her granny and said, "Granny, may I have a candy?" and Granny, looking up from her sewing said, "Yes, dear—one, and one only." When Janet replied, "One and one only, that makes two," there was no malice intended, but there was a misunderstanding.

Towards Better Understanding

Training programs, refresher courses, and staff conferences keep the nurse up-to-date on newer trends in hospital care, on policies, and on procedures, and allow an opportunity for the nursing personnel to make suggestions that will promote better nursing service.

Directions can come to the nursing staff through the director of nursing, the supervisor, and thence to the head nurse and nursing staff.

Nursing committees provide management with helpful suggestions from the nursing viewpoint on policy formation, purchase of equipment, improved procedures, and solution of problems within the scope of their competence. We should not overlook one weakness of committees, however — the tendency to be preoccupied with their own departments.

Harmony within the department is only possible if each understands and accepts his or her own position.

Good human relationships depend so much upon good supervision that the selection, training, and motivation of those who are to supervise others demands particular attention.

Professional and practical nurses work well as a team when duties are definitely assigned. The professional nurse must be conscientious and sincere in her guidance and supervision. She must be able to give good bedside care as well as function as a teacher. She must know what supervision is *not*.

The practical nurse and the orderly must also realize the exact extent of their responsibilities, and be willing to accept guidance from the professional nurse. The student nurse should do all that is expected of her within the limits of her training and experience, and work closely and harmoniously with the nurses on the ward. Although the ward aide is not properly a member of the nursing team, her services can be a positive contribution towards a better environment for the patient. The patient may not understand the techniques of nursing but he can appreciate good housekeeping and a smile.

These are specific ways in which each of you can help to promote better interdepartmental relations.

- Reports on critically ill patients should be sent promtly—promtness is essential in notifying the proper persons of deaths.
- Accurate day and night reports are vitally necessary if the information clerk is to answer calls about patients satisfactorily.
- Prompt notification to the business office of impending discharges furnishes correct information about beds available, and facilitates collection (money also helps in providing patient service).
- Requisitions should be sent to the storekeeper at the proper time, for sufficient quantities to last until the next issue day.
- Try economy in use of supplies.
- Linens, et cetera, should be used properly.
- Be prompt in requisitioning needed repairs; use the standard forms provided.
- Try to work closely and harmoniously with the dietary department to provide both regular and special diets.
- Co-operation with the medical records department is essential, and will exist if the nurses are careful to see that charts are properly assembled. Although the physician must complete the chart, the nurse can assist him.
- For notification of cases which show evidence of infection most hospitals now use a form entitled "Report of Infection In Hospital" prepared by the attending doctor.
- Patients going for x-ray, to the laboratory, or to the operating room should be properly prepared and sent promptly.
- The nurse can co-operate in the matter of medical education by making available for undergraduates and interns any interesting or important clinical material on the ward.
- Follow the standard procedures set up by the central supply room for requisitioning, obtaining, and return of sterile and unsterile supplies, treatment trays, heating pads. Trays should be cleaned, and steri-files returned daily, the syringes well rinsed. Damaged or broken articles should be reported by the individual responsible for the accident.
- The wise nurse finds ways of co-operating with the social service department, and a thinking social worker can contribute much to the knowledge of the doctor and nurse about the patient as an individual.
- Notify the chaplain or the patient's priest or minister promt-

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With the Auxiliaries

The 1958 officers of the Women's Hospital Auxiliaries Association of Ontario are, from left to right: Mrs. Vance Glazebrook, Sault Ste. Marie, Treasurer; Mrs. C. G. Fraser, Hamilton, Recording Secretary; Mrs. W. C. Vaughan, St. Catharines, President; Mrs. H. Ramsay Park, Trenton, Secretary of Regions; Mrs. O. J. Stahl, St. Catharines, Corresponding Secretary. Absent is Mrs. A. H. Lyon of Windsor, public relations director.

Volunteers in the Future

The continuing and increasing need for volunteer hospital workers was clearly evident in each discussion and address at the annual meeting of Manitoba Women's Hospital Auxiliary Association held in Winnipeg, October 30 and 31.

Programs which would alleviate loneliness among the aged and ill were urged in the opening session by Ina Broadfoot, director of nursing services, Red Cross Society, Manitoba Division, and Rae Abernathy, executive director of the Age and Opportunity Bureau. Even with increased federal assistance there will be too many old people living on too little money. The auxiliaries were asked to extend their activities into old people's and nursing homes, and to visit the aged. In understaffed rural hospitals there are many needs that can be filled by volunteer workers; Red Cross home nursing courses were offered as training for volunteer nurses' aides. When auxiliaries help patients, directly or by correspondence, when they provide chapels and set up bursaries for nurses, the speakers felt, they are fulfilling a real need.

In the next five years the need for voluntary workers will be even greater, asserted T. A. J. Cunnings, president of the Associated Hospitals of Manitoba. The national hospital plan would cover the basic necessities, but the 8,000 paid hospital workers will need the help of the 7,000 auxiliary members as much if not more than before. What the voluntary workers give cannot be counted in money, he felt.

R. W. Queen-Hughes, guest speaker at the luncheon, credited the auxiliaries for their public relations work. "For good public relations," he said, "an organization must possess the virtue of honest endeavour; have excellence of performance as an ideal; and must be convinced that the job they are doing, the service they offer, the goods they manufacture, are in the long run socially useful. The standard of morals expected from the individual applies equally to the corporate entity . . . Good public relations is the outward and visible sign of an inward and spiritual grace."

Elected as *president* to succeed Mrs. G. Davis of Belmont was Christina Macleod. *Vice-presidents* for 1958 are: Mrs. W. D. Aime, Clandeboye; Mrs. G. H. Evoy, Winnipeg; Mrs. H. Lippman, Beausejour; Mrs. C. S. Grant, Brandon; and Mrs. F. Law, Winnipeg. *Recording Secretary* is Mrs. W. E. Barnard; *corresponding secretary*, Mrs. H. G. Marsden; *treasurer*, Mrs. T. A. J. Cunnings; *public relations*, Mrs. A. S. Williams; *regional director*, Mrs. G. L. Carr.

Cafeteria-Style

The Johnston Heights Hospital Auxiliary held a very successful supper in the fire hall, serving it cafeteria-style. The proceeds will help to furnish a ward in the new 4-bed Surrey Memorial Hospital, Surrey, B.C.

For Hydrotherapy Equipment

A cheque for $2,000 was presented to the administrator of Winnipeg municipal hospitals by the Princess Elizabeth Hospital Guild. The money, raised at the guild's annual tea, will be used to purchase equipment for the hydrotherapy pool recently opened at the hospital—parallel bars, an overhead trolley, stainless steel chairs, shower curtains, bathing suits and towels.

"Our Island Story"

Proceeds from sale of the book, *Our Island Story*, have been donated to the Ladies' Aid of the Prince County Hospital, Summerside, P.E. I., by its author, Carrie Holman.

Operation Pancake

Seven stoves were manned by local doctors and business and other professional men, under the direction of a chef, when the Men's Association of the Prince Edward Island Hospital put up a pancake and sausage supper. To serve the fare hot off the griddle, the 1,500 who attended were lined up and served cafeteria-style. This is the largest project yet attempted by this fairly new organization of men whose purpose is to help the hospital. They were very pleased with the results of "operation pancake," —a net profit of $1,400.

Contest Winner

The essay of Mrs. J. K. Lang, Peterborough, Ont., was selected as winner of the contest conducted by the *Volunteer*, an Ontario Hospital Association Auxiliary periodical. Mrs. Lang read her essay, "What auxiliary work has given to me", at the annual meeting of Peterborough's Civic Hospital Women's Auxiliary, of which she is a member.

Not Only A Rose

Norway maples, various shrubs and other flowers as well as roses have been purchased for the Hotel Dieu in Perth, N.B., by the Hospital Aid Society. The ladies' tag day and food sales have also helped to pave the roadway and the parking area of the hospital.

Successful First Year

The Ladies' Auxiliary of Western Memorial Hospital, Cornerbrook, Newfoundland, has reported a highly successful year. Retiring president, Mrs. F. A. Janes, was able to make this satisfying report in spite of the fact that the auxiliary was formed only a year ago

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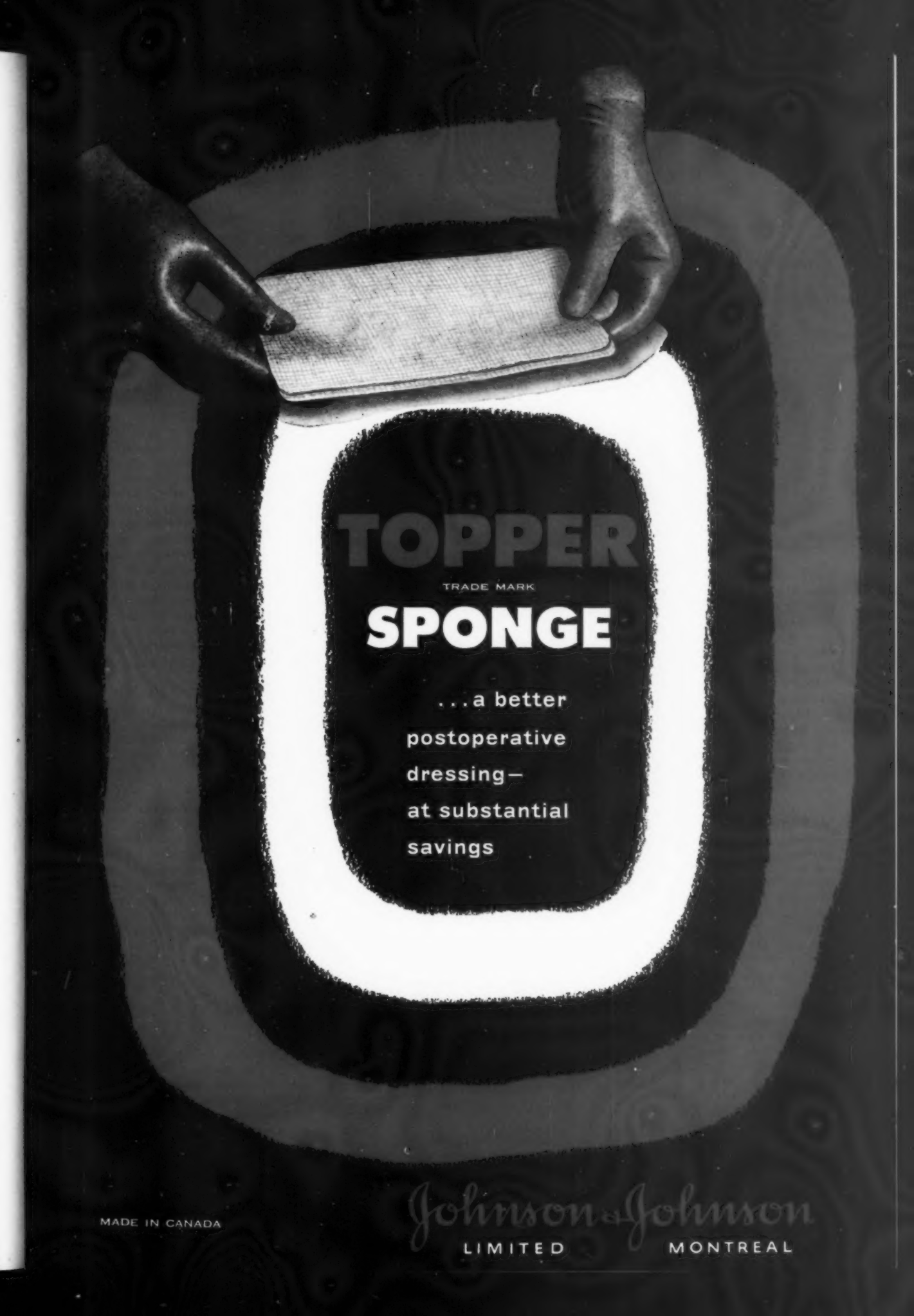
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Provincial Notes

British Columbia

—*A. S. & M. News, Abbotsford.*

When the new 50-bed Matsqui-Sumas-Abbotsford General Hospital was opened at Abbotsford in 1954, its furniture and equipment were financed by the people of the district. Even then name plates on the ward doors did not seem the right way to recognize donations which had been used to furnish and equip not only the bedrooms, but every room in the hospital.

The scroll (above) which he is shown presenting to Eldon Jacobson, chairman of the Board of Management, is the work of W. Langdon-Davies, a member of the hospital board. This parchment, listing the names of the organizations, churches, and individuals who contributed, is in Old English lettering and full colour. It now hangs in the main entrance of the hospital.

A new fracture ward has been opened at St. George's Hospital, Alert Bay. The ward bears the name of Russell Mills, in honour of his leadership and service in St. George's Hospital Society since 1947. It is furnished with fracture beds, adjustable over-bed tables, and comfortable chairs.

Pupils of Kaslo elementary school have been helping Victorian Hospital of Kaslo for several years by purchasing equipment as well as children's toys. This year they have donated a humidity tent.

A new wing has been opened at Terrace and District Community Hospital. The 14-bed extension has been furnished so that the new equipment can be easily transferred to another building when the hospital expands.

A small private hospital for chronic and convalescent patients has been opened at Willow Point. The Willowhaven Private Hospital occupies a converted private home.

St. Joseph's General Hospital, Comox, will receive $662 from the provincial government for damages caused by a rainstorm this summer. Highways department crews were reconstructing the road in front of the hospital when the storm struck. The water, unable to escape into roadside drains, cascaded into the basement of the hospital.

N.W. Territories

A new hospital has been opened at Hay River. The H. H. Williams Memorial Hospital will be under the guidance of the Pentecostal mission. Rev. K. Gaetz, now in charge of this mission, has been a moving force in the building of the hospital. The $80,000 required was furnished by the federal government, local residents, and the H. H. Williams Memorial Fund.

Alberta

Calgary's vacant old general hospital building will not be demolished as had been suggested, but will be used for some administrative or general health purpose. Since it was vacated as a hospital five years ago it was used temporarily as a nurses' home.

Completion date for Grande Prairie's new $750,000 hospital addition has been extended by two months. Although part of the building has been encased in plastic film to permit work during the winter, supply shortages and poor construction weather have held up building progress.

Saskatchewan

Tenders have been called for construction of a new union hospital for Rabbit Lake. The architects for the project are Webster and Gilbert of Saskatoon.

The Kinistino Union Hospital has installed a new x-ray machine. Pieces of equipment are purchased as the hospital can afford them.

A new nurses' residence was officially opened recently at Wynyard by health minister Walter Erb.

Manitoba

Winnipeg General Hospital will receive $10,000, and the Winnipeg Children's Hospital $5,000 under the will of Charlotte Osborne. Miss Osborne's bequest to the General is in memory of her mother and aunt who graduated as nurses from the W.G.H. in 1893.

Brandon General Hospital has been fully accredited for three years by the Joint Commission on Accreditation of Hospitals.

Dynevor Indian Hospital, four miles north of Selkirk, is being closed because of reduced incidence of tuberculosis among Manitoba Indians. Transferring patients in this 55-bed Dynevor hospital to sanatoria at Brandon and The Pas will provide all the treatment required at a saving in cost. The program for prevention and control in the area will not be relaxed.

Wawanesa and District Memorial Hospital will receive an addition. The extension drawn up by R. Brown will relieve the recent overcrowding of its 5-bed capacity.

Ontario

The sod has been turned for construction of the new 100-bed St. Joseph Hospital in Elliot Lake —officially at any rate. Construction has begun on the four-storey brick structure even if the ribboned shovel did refuse to enter the ground for Mother St. Bride, head of the religious order in North Bay.

Brantford General Hospital is receiving $42,728 from the estates of Mr. and Mrs. C. A. Waterous. The Welland County General Hospital has received the first installment of a $1,000 pledge from the Welland Police Association.

The chairman of Toronto Western Hospital's successful fund-raising campaign turned the sod for an extension to the out-patients' department. Architects for this addition, the first step in the hospital's $5,210,000 three-year expansion program, are Govan, Fer-

(continued on page 75)

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Notes on Federal Grants

Construction

Extensive alterations to the Notre-Dame de Chartres Hospital at Maria, P.Q., will be assisted by a national grant of $42,000. The present 74-bed institution is to be enlarged to accommodate 108 beds, and nurses' beds will be raised from eight to 24.

Operated by the Sisters of St. Paul of Chartres, the enlarged hospital is expected to be ready for occupancy in March, 1958.

The construction of a new 65-bed hospital at North Surrey, B.C., will receive assistance from a federal grant of $77,310. There will also be accommodation for 17 bassinets.

To be known as the Surrey Memorial Hospital, and to be operated under the B.C.H.I.S., the new institution is scheduled to be completed by May 1, 1958, and will be financed by local funds and provincial grants as well as the federal assistance.

A federal grant of $4,330 to the Providence Hospital of Moose Jaw, Saskatchewan, will be applied towards additional floor area for laboratory services, the accommodation for which is at present inadequate. An autopsy room, animal room, pathologist's office and histopathology and biochemistry departments will be incorporated in the new brick and tile structure. It will also allow for the re-allocation of space for general chemistry. The hospital is operated by the Sisters of Providence of St. Vincent de Paul, who, with federal and provincial assistance, will finance the new building.

More than $64,500 will be given to the Vancouver General Hospital for the cost of a new building housing the pathology department and providing an x-ray film storage area. The main laboratory has been situated in a building erected in 1942 and the space made available by its removal to the new quarters will probably be assigned to the B.C. Medical Research Institute or the Department of Physical Medicine. The Vancouver General is a highly specialized institution serving the province as a whole, and contains 1,294 active treatment beds.

A grant of more than $55,000 to the Alexandra Marine and General Hospital at Goderich, Ontario, will go towards the construction of a new two-storey wing in which will be accommodated medical, surgical and obstetrical services. The addition will raise the number of active treatment beds from 58 to 97, as well as providing nearly 1,600 square feet of additional accommodation for the community health centre and space for a 22-bassinet nursery. Construction of the concrete and brick building has been under way for almost a year, and it is expected to be completed by the end of 1957.

Erection of a building for a Cobalt 60 therapy unit at the Kingston General Hospital, Kingston, Ont., will receive nearly $5,000 assistance from the federal government. The cost of the one-storey addition to the 470-bed hospital which will house the unit is being shared by the hospital itself, federal and provincial governments, and by the Ontario Cancer Treatment and Research Foundation.

Two new Alberta hospitals, the Bow Island Municipal Hospital, Bow Island, and the John Neil Hospital at Cold Lake, will each receive $23,000 to aid their construction. Previously without a hospital, by May 1958 Bow Island will have 21 active-treatment beds, eight bassinets in cubicles, a solarium, laboratory and other services. A nurses' residence with accommodation for ten and a matron's suite, will also be built.

The John Neil Hospital, owned by the Women's Missionary Society of the United Church of Canada, will be a frame structure containing 28 active-treatment beds, eight bassinets, a solarium, x-ray department and ancillary services.

The new hospital at Castlegar, B.C., has been granted $42,000. The hospital, which serves the district surrounding Castlegar as well, was begun last May and should be completed by September 1958. Accommodation for 16 medical and surgical beds, a paediatric ward for five, isolation section for four and a maternity section for eight beds with ten bassinets has been scheduled. Areas for diagnostic and treatment facilities also will be provided, along with a community health centre.

The building will be of reinforced concrete construction, with one main floor. Financing will be undertaken, apart from the federal assistance, by a provincial grant and local taxation.

The enlargement of the Union Hospital at Paradise Hill, Saskatchewan, will be assisted by a National Health grant of $4,435. Two active treatment beds will be added to the nine-bed hospital as well as a combined operating and case room, utility and work rooms, and an out-patient service area. Begun last summer, the building is due for completion some time in 1958.

A federal grant of slightly more than $10,000 has been approved for the St. Jean de Brébeuf Hospital, Sturgeon Falls, Ont. The grant is to go toward the cost of increased nurses' accommodation and training facilities for nurses' assistants. The hospital is operated by the Order of the Daughters of Wisdom.

A new cottage hospital is to be opened in Uxbridge, Ont., with the federal assistance of more than $35,000 going towards the building costs. The building will have 29 active treatment beds to accommodate medical, surgical and obstetrical patients. There will also be an area for diagnostic and treatment purposes and an eight-bassinet nursery.

Being built as part of the Quebec program of extending hospital services, a new 97-bed hospital in Loretteville, Que., has been granted $98,000 by the federal government. The institution is to serve ten localities with populations totalling about 40,000. Known as the St. Ambroise de Loretteville Hospital, it will have active treatment beds, newborn nurseries, and modern treatment facilities. The building is expected to be completed by the summer of 1958.

Home Care

Federal assistance for a medical home-care program being instituted in the city of Toronto, Ont., will amount to $17,655. This pilot project, which is hoped to have a bearing on a more econ-

(concluded on page 62)

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The plastic material consists of a micro-porous extensible filter, air-permeable yet waterproof.

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Elastoplast 'Airstrip' is made from a specially developed plastic material, through which sweat and skin exudates evaporate at the same rate as they develop on the skin. The material is a micro-porous extensible filter, and is not perforated. It provides a barrier to water, grease, oil and infective organisms. Even after long application, Elastoplast 'Airstrip' does not cause maceration. The adhesive is specially spread in a lattice pattern so that micro-porosity is retained and firm adhesion not impaired. The surface of the wound and the surrounding skin remain dry beneath an 'Airstrip' dressing, which can be left on until the wound heals.

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Elastoplast 'Airstrip' First Aid outfit containing 120 dressings of assorted sizes (Order No. 7957).

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Federal Grants

(concluded from page 60)

omical allocation of hospital beds, is to be tested in one of Toronto's eight health districts. Under the plan, a number of home-bound patients, including some chronically ill, will be provided with a full range of existing home services, voluntary and otherwise, and will be co-ordinated through one administrative agency with the family physician as a central figure. The project will operate for three years at least.

Public Health

The International Grenfell Association, providing northern Newfoundland and Labrador with medical and hospital services, is to receive a grant of $20,000 to bring better radio-telephone communications among its stations and ships. The new set-up will provide 10 shore stations and radio telephone sets for three motor vessels.

More than $26,000 has been allocated to a new Ontario health unit by the federal government. The unit is being set up in Ontario County—Southern Area, which includes the towns of Ajax, Uxbridge and Whitby, the village of Pickering and the townships of East Whitby and Pickering. It began operations in July of last year to provide full-time generalized public health service for a population exceeding 30,000.

Nearly $28,000 from the federal government will go towards the setting up of a new health unit in Port Arthur, Ontario. The area to be served includes Port Arthur, the townships of Nipigon and Shuniah, the improvement district of Dorion and the unorganized territories of Copenhagen Road, Dog River, Hurkett, Kaminintiquia, Lappe, Mud Lake, Pass Lake, Stepstone and Toimela. When fully staffed, this full-time generalized public health service requires a doctor, nine nurses, two sanitary inspectors and a clerical staff.

Diagnostic Services

St. Jean-Eudes Hospital at Havre-St.-Pierre, Que., has been granted more than $9,000. This assistance is to be applied towards technical and scientific medical equipment.

The province of Alberta has been granted just over $400,000 to assist in plans to raise the standards of laboratory and x-ray equipment in 63 hospitals. Approximately $350,000 will be spent on x-ray apparatus and the remainder on laboratory equipment. There will be exchange of present x-ray apparatus among a number of hospitals to facilitate the plan's objective of distributing diagnostic equipment in the most effective manner.

Research

A research project on the causes of cleft lip and palate, to be carried out in the Royal Victoria Hospital, Montreal, is to receive federal assistance to the amount of $8,000. The discovery of means for reducing the number of congenitally handicapped children would result in a substantial reduction in beds for hospitalization and the cost of treatment and rehabilitation. The project, being directed by Dr. Hamilton Baxter, surgeon-in-charge of the sub-department of plastic surgery, is expected to be concluded by March 1959.

"Dynamically Different Program" at A.C.H.A. Congress

The first Congress on Administration, a commemorative program for the college's 25th anniversary, is to be held in Chicago, February 9, 10, and 11. The planning committee, headed by Ray E. Brown, superintendent of the University of Chicago Clinics, has scheduled Sunday afternoon for registration and an informal reception in honour of the founders of the college. Subjects for the seminars which are to follow breakfast on Monday morning have been carefully selected; each subject is related to the science of administration so that the administrators who attend will be brought up-to-date on the latest advances in progressive management.

Tuesday morning a second battery of pertinent subjects will be examined by leaders and specialists in the different aspects of management. In addition to the special seminars which are to be selected according to the particular interests of those who attend, there will be four general assemblies.

A prize book will be selected by a committee headed by J. A. Hamilton, director of hospital administration at the University of Minnesota, for a $500 cash award. Special citations will be awarded to the founders of the college at the banquet. The most outstanding article published on the subject of administration in hospitals will be selected also.

It's better to give than to lend, and it costs about the same.—*Philip Gibbs.*

Protection from FIRE

K. J. Partington,
Provincial Fire Marshal,
Halifax, Nova Scotia

FIRE precautions in hospitals have greatly improved during the past ten years. Our department is sought out by many institutions to help them with their problems —which is really as it should be. The fire services are now represented on most building code committees, and modern codes contain greatly improved fire prevention sections. Life safety is really the basic reason for any building code, and fire can hit any building.

Many ideas have been advanced, aimed at removing completely the danger of fire and its effects. However, frequently some little item is overlooked and fire strikes the "fire-proof" building.

Safety starts with the building itself. We know that there are two types of hazards, the common ones, and the uncommon or special hazards. The type of occupation can cause these "special hazards" as they are peculiar to a particular trade or occupation. The principal common hazard in the average building is open stairways and open hallways. When fire occurs heat rises rapidly through these horizontal and vertical arteries cutting off escape and taking lives. Fortunately there are some effective remedies, such as bottling up these vertical arteries throughout a building, and providing alternative avenues of escape. By enclosing the vertical shafts, the fire is contained long enough for the occupants to get out. It is within the first fifteen minutes after the outbreak of the fire that lives are taken. The danger is in the heated air and noxious gases that are produced.

It is the responsibility of architects and also of administrators to eliminate hazards of fire in the initial stages of planning a building. Safety begins on the drawing board. However, should hazards still exist in a building, there are a number of effective remedies that may be employed, one of which is automatic fire detection systems. These are electronic devices known as "sentries that do not go to sleep". Also there is the automatic water sprinkler system which detects the fire within a few seconds after it starts. This works immediately on the fire, and gives an alarm which allows the occupants to get out, if necessary. Fire departments answer these calls immediately and, after checking, they put the system back into operating order.

Hazards in the Operating Room

Peculiar to hospitals are the combustible anaesthetics. Ether is dangerous as it has a very low ignition point and it takes but a spark to set it off. Another anaesthetic, cyclopropane, is as dangerous as gasoline, one gallon of which is equal to 88 sticks of dynamite in explosive potential. In all these combustible anaesthetics the danger is usually near the patient's head, unless a leak occurs somewhere in the system. These hazards are very serious in any hospital although they are not the greatest cause of fire in hospitals. When fire does occur in an operating room it frequently results in loss of life. In one hospital a surgeon was performing a tonsillectomy on a child when a static spark ignited the anaesthetic. The surgeon snatched the child and ran into an adjoining room where he completed the operation. The patient in this case suffered severe burns but recovered. On investigation it was found that rubber mats had been placed on the floor on each side of the operating table. This insulated the doctor from the floor and resulted in the build-up of the static charge. Of course, all hospital officials know well that a conductive floor is required, and that rubber mats or shoes are a real danger in an operating room. However, this did happen in one of our hospitals, so we must not relax our vigilance if such events are to be prevented.

Two lives were lost in Nova Scotia in recent years through people smoking in oxygen tents. An electric razor should not be used in an oxygen tent, nor anything that will cause a fire. Woolens should not be allowed nearby; even combing the hair can start off the pattern of events which takes lives. These problems are all familiar. Actions like scraping your feet in the operating room can set up enough voltage to cause an explosion. Recently a fire took place in a new fire-proof hospital. It gained headway because the ceiling tile was not fire-proof. There would have been deaths if there had been patients on that floor.

Extinguishers

Carbon dioxide is the right extinguisher for an operating room. The nurse must know how to use the extinguisher and she must learn to operate it beforehand.

Carbon tetrachloride is an excellent extinguishing agent but we do not recommend it for use inside a building. We have it on the best of authority that it is a deadly killer. It is a recognized fumigant. Turned on sodium it will cause an explosion. The fumes can be very dangerous to you and can attack the fatty tissues of the brain. It was barred from the United States Navy because it was the cause of a number of deaths among servicemen. In Nova Scotia a coroner's jury found that it was the cause of a man's death. If you have a carbon tetrachloride extinguisher or a vaporizing chemical, do not take any chances. Get clear of them. The best extinguisher for an ordinary fire is water. Baking soda is good for a grease fire.

This is only a brief outline of some of the fire problems in a hospital. Any fire officer will be glad to help you with your fire safety program. It is your job to maintain the preventative measures. It is the job of everybody connected with the hospital to prevent a fire. We all have one purpose, and that is to save lives.

From a paper presented at the 1956 annual meeting of the Maritime Hospital Association.

Food Production Target

The large proportion of the world population whose diet is not good enough to prevent nutritional deficiency diseases, is no longer willing to be content with its miserable pre-war diet. The target must be the amount required to maintain health.

Farmers would never think of setting a lower target for their cattle, nor military authorities for army mules.

In Western civilizations, the food production target has been, not the amount needed to supply human needs, but the amount that could be sold at a profit. If there were a world guaranteed market for food at a price which would yield a return on capital comparable with that of oil, which is said to yield 17 per cent on capital employed, the world food shortage would not last long. — *Hamdard English Digest.*

Coming Conventions

Feb. 7-8—Midyear Conference of the American Hospital Association, Palmer House, Chicago, Ill.

Feb. 9-11—25th Anniversary Commemoration and Congress on Administration of the American College of Hospital Administrators, Congress Hotel, Chicago, Ill.

Mar. 3-6—Joint Nurses-Surgeons meeting sponsored by the American College of Surgeons, Commodore Hotel, New York City.

Apr. 14-16—College of General Practice of Canada, second annual scientific assembly, Royal Alexandra Hotel, Winnipeg, Man.

June 12-14—Canadian Association of Physical Medicine and Rehabilitation, annual meeting, Quebec City, P.Q.

June 16-20—Canadian Medical Association Convention, Nova Scotian Hotel, Halifax, N.S.

June 17-20—16th annual convention of the Canadian Society of Radiological Technicians, Fort Garry Hotel, Winnipeg, Man.

June 21-22—Conference of Catholic Schools of Nursing, annual meeting, Atlantic City, N.J.

June 21-26—Catholic Hospital Association of the United States and Canada, annual convention, Atlantic City, N.J.

June 23-27—Canadian Nurses' Association 50th Anniversary Meeting, Lansdowne Park, Ottawa, Ontario.

June 25-27—Comité des Hôpitaux du Québec, annual convention and Commercial and Scientific Exhibition, Montreal Show Mart, Montreal, P.Q.

Oct. 15-17—The Saskatchewan Hospital Association, annual meeting and institute, Bessborough Hotel, Saskatoon, Sask.

Red Cross in Vienna

(concluded from page 50)

er agreed to put it through his grinder; and afterwards it was mixed with onion and paprika, salt and perhaps carraway. The result?—a most acceptable and popular spread. The other spread that I never did get quite used to serving was *schmalz*—our lard or dripping served with paprika, salt and raw onion. It sometimes helped a scanty meal. Until May, an apple was served once a day. We had no citrus fruit or other fresh fruit, but on occasion we had prunes.

To supplement the diet the medical department supplied vitamins for everyone old enough to swallow. Drops were destined for the young children. This supplement was issued every day at dinner time just before the meal was served.

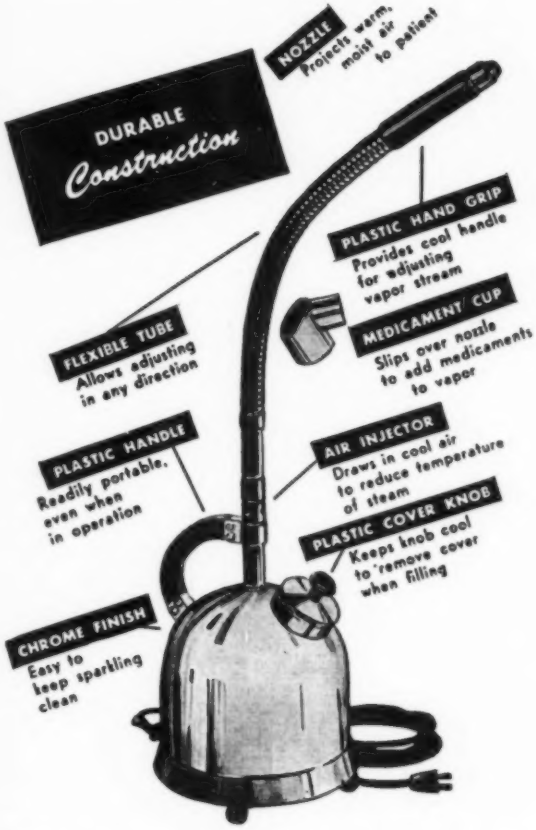
After two or three weeks we realized how impractical it was to serve everyone from the main kitchen. Therefore the medical department arranged to make a room available in their building. We bought a stove at a second-hand store, plus some pots and pans, figuring to serve about 20 people. It was decided that all children up to three years of age would eat here, as well as anyone given an order by the doctor for a special diet. Because we were a transient camp with a population which changed frequently, we realized that our original estimate of 20 fell very short, and at one time we had over 60. We had to buy larger pots and fitted in what food we could from the main kitchen. Besides special diets and feeding the "under threes", supplementary rations were given mid-morning and mid-afternoon to all children under 12, pregnant women, and to whomever the doctor deemed necessary. These supplementary foods consisted of milk or cocoa in the morning and an orange, or other fruit, in the afternoon.

How did the refugees get to a camp? After crossing the border they were directed or taken to a camp that looked after their immediate needs—food and shelter. This would be a staging camp and they would only stay there for two or three days. Any movement of the refugees was the concern of ICEM—the Intergovernmental Committee for European Migration which has been in operation in Europe since the division of East and West and the war made shifting populations a world concern. ICEM may sound like a set of letters, which it is, of course—or a word, which it has become; but to us it meant people coming or going. Usually ICEM warned us well in advance, but sometimes there would be a slip-up and we would have 300 extra for dinner just at twelve o'clock. Or else two bus loads would arrive, after the stores were closed, to be given blankets and a bed to sleep in. Whenever it was necessary to move any group, ICEM provided transportation—usually buses from the staging camp to a permanent camp and then to a transient camp such as ours, and then from our camp, on a long train journey to a port of embarkation. For these trips, which might mean 24, 36, or 48 hours' ride, we provided the train rations in some cases, but for a very large movement an agency in Vienna sent them all ready put up. We were always very grateful for this, especially if we had to serve breakfast at three or four in the morning. These train rations consisted usually, of of a loaf of bread, a bag containing a piece of wurst, sardines, cheese, and chocolate. If we had any tid-bits we tried to include them, for it was staying food, but rather dull. Canned milk was provided for babies. At main stopping points the local Red Cross served a beverage.

I have dwelt at length on the food service at the *Artillerie Kaserne*, but I would not presume to forget that I was only one-seventh of a real working team. I feel that the use of the word "team" is a good one, because I know that without the support and encouragement from the others, we could not have worked as effectively.

We all came back with every sympathy for the new Canadians in their struggle to learn our language. We were removed from the cosmopolitan areas where you can usually find someone to speak your tongue. For the first time, in the real sense, *we* were the foreigners, and no matter how loudly a voice is raised or how many gestures are used, unless you know what a person is talking about, you're helpless.

THE MYRICK INHALATOR



Note: Action of air injector can be demonstrated as follows: Start Inhalator in operation and when vapor is being projected from nozzle, wrap a handkerchief or other material over the four holes in tube just above handle. This cuts off air supply and steam coming out of nozzle will not be projected. Remove handkerchief and notice how vapor is again projected.

Entire contents of Inhalator must come to a boil. Warm up period can be reduced by filling with hot water.

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Book Reviews

REMOTIVATING THE MENTAL PATIENT by Otto von Mering and Stanley H. King. Published by the Russell Sage Foundation, New York, 1957. Pp. 216. Price $3.00.

This report is the outcome of the work and thought of many people who are dedicated to the premise that the effects of long term mental illness are partly and even wholly reversible. In part they have attempted to answer (or suggest an answer to) two major questions: how can the entire mental institution be converted into a therapeutic centre with diverse but co-ordinated forms of therapy provided by many different groups of staff; and what is the place of the hospital among various kinds of treatment facilities?

The success of the undertakings in improved patient care reported in this book rests entirely upon what has been termed "social remotivation"—the considered use of the social and psychological components of ward living, and more extensive or better coordinated utilization of the resources of the hospital as a whole and of the community beyond the hospital walls.

There is a selected bibliography of generally recent publications dealing with the philosophy and technique of intensive environmental treatment of mental patients. This book will be of particular interest to those engaged in psychiatric work in mental hospitals.

THE WINNIPEG GENERAL HOSPITAL SCHOOL OF NURSING, 1887-1953 by Ethel Johns. Published by the Jubilee Committee of the Alumnae Association. Illus. Pp. 87. Written as a "labour of love", it is sold at $2.00.

The 70-year lifetime of the school of nurses is traced to its jubilee year, right from the meeting in 1872 at which citizens decided that it was high time that the "muddy hamlet" of Winnipeg had a hospital. "Old inhabitants who drank their Red River water raw, rendered their alimentary canals poison-proof," but later settlers were developing typhoid.

In the first 12-bed ward set up, "patients would care for each other when able to do so, assisted by any help that could be obtained." In the new 72-bed hospital opened in 1884 by a charity ball, the nursing superintendent had authority over the five nurses only when they were off duty. The nursing school organized by 1887 was completely under the medical supervisor. Payments for the services of pupil nurses reverted to the hospital—"a mild type of peonage that proved quite profitable."

Dr. Johns gives personality to the regulations of the first school through the experiences related by Mary Ellen Birtles, the first student. When 1894 brought a strong new women superintendent, curriculum and staff were enlarged. Although uniforms have since been streamlined, today's cap was worn with the original "atrocious outfit." Miss Johns shows us both the personality and impact of each superintendent as she describes the development of the school through boons, like the donation of the Nurses Cottage, and blights—from scarlet fever to the 1950 flood.

This is a document of the history of the Training School for Nurses at Winnipeg General Hospital, but is also a busy, happy little book jacketed in pictures and filled with people.

YOU AND YOUR OPERATION, by Benjamin R. Reiter, M.D. Published by Brett-Macmillan, Ltd., Toronto, Ontario, and the Macmillan Company, New York, N.Y., Pp. 150. Price $3.50.

Convinced that an informed patient can be an active participant on the operating team, Dr. Reiter has written this book to explain some of the more common events involved in surgery in the language of the layman. The patient who knows what to expect will be less anxious, more relaxed and cooperative.

Medicine itself is introduced first, in a grimly humorous account that traces its emergence from ignorance, mysticism, and superstition. Unlike the 16th century, when a wound healed more quickly if the physician treated the weapon, Dr. Reiter emphasizes that today an operation is truly beneficial. He takes a fictional Mary Roberts through her operation—breaking the news, entering the hospital, preparing for the operation, receiving cards from people she hasn't heard from in months, while the doctor answers her questions and calms her fears. He explains anaesthetics. He tells you what a patient can expect in the operating room, what and how he will feel afterward. To clear up some common misconceptions he explains such hospital procedures as biopsies and catheterizations, and puts appendicitis, hernia, gallstones, and varicose veins into words a patient will understand. Colostomy, radical mastectomy, hemorrhoidectomy, hysterectomy, and amputations — the "fearful five", are accounted for, and a full chapter is given to cancer. Not only is the patient given directions for finding a capable, modest surgeon, but he is told what he, as a patient, can contribute — co-operation and courage.

Although the objective, informed reader would find his "this may hurt but think how much better you will feel afterward" approach rather patronizing, to someone shivering in fear and ignorance before the prospect of an operation Dr. Reiter's book would provide welcome information and assurance. It would be very good reading for worried friends and relatives.

Auxiliaries

(concluded from page 56)

and the members had very little idea of just what was expected of them.

During the year the auxiliary contributed $1,364 in gifts to the hospital and has a healthy balance of $710 in the bank to start the new year. The ladies have also undertaken to visit patients, provide a bedside wagon, and organize birthday and sewing clubs.

For Deep Heat Treatment

St. Elizabeth's Hospital, Humbolt, Sask., recently received the latest in diathermy machines through a donation from the hospital's ladies' auxiliary. The new equipment, valued at $700, is used for deep heat treatments.

A Shampoo Chair

Long-stay patients in the chronic ward of the Royal Alexandra Hospital, Edmonton, Alta., have been furnished with a shampoo chair by the Women's Auxiliary. The ladies also decorated the ward for Christmas.

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7-6

(concluded from page 37)

line in studying the question of whether—in Saskatchewan, at any rate—small hospitals serve best in somewhat more limited functions such as those confined to general medical care, maternity service, and minor and emergency surgery.

Another example relates to application of utilization data for control of admission rates. In some hospitals the admission rate for dental surgery continued, year after year, at a higher level than the 3.1 per 1,000 population province-wide average. Detailed study showed that, in those hospitals with rates far above 3.1, inpatient hospitalization was not actually required for many of the procedures. As a result, more precise criteria were established so that cases could be diverted back to care in dentists' offices, where these offices existed.

Utilization data have also been exploited in studies to improve administrative practice. The question asked here was: How many days' delay should there be between the date of admission and the date of surgical operation? In some hospitals and for some procedures this delay was substantially longer than the provincial average for that type of hospital. Preparation of data of this kind usually had this effect—the hospital itself instituted the correcting mechanism. The problem was simply that the hospital had not been aware of lack of internal co-ordination in scheduling of admissions in relation to scheduling of the operating rooms.

Controls

The foregoing examples represent techniques for conscious direction intended to influence the volume of utilization. For it must not be thought that a readily available hospital care service is a service without control. The advent of comprehensive insurance removes what might be termed the automatic control exercised by the individual's pocketbook when patients must pay for part or all of the services directly. Conscious direction of the developing service must therefore be introduced to ensure reasonable utilization of the now freely available care. But when the goal is a health service implying a higher standard of care for all beneficiaries; and when the operations of the administering authority are referable to the entire complex of hospital facilities and services—and not merely to the narrower concern of "protecting the fund"—then the question of controls takes on new light.

For example, it is difficult to define the term "misuse". Very high admission rates to hospital are sometimes considered one form of misuse of services. Close analysis of high utilization, however, reveals that "misuse" is unsatisfactory terminology to describe highly complex phenomena.

First of all, hospitals must be defined in terms of their size, their function and their location. Information must be sought about the types of patients admitted. Are they old or young, farmers or townsfolk, wealthy, self-supporting, medically indigent, or wholly indigent? What are their ailments? Are these patients hypochondriacs or are the majority genuinely ill and suffering from conditions which are remediable under hospital care? Has the hospital an admission policy conducive to higher than average admissions? Do doctors in a given area, as contrasted with another area, tend to admit more patients for observation and diagnosis? Do these doctors tend to keep patients in hospital a few days longer for convalescence? Is this a good thing or a bad thing, for the particular area, or the particular hospital, or the particular patients under review?

The challenge is to find answers to these questions. Only then is the policy-making and administration authority in a position to make statements as to what constitutes misuse. Only then, too, can the question of controls and deterrents be considered in relation to all their effects. For example, a control or deterrent which has the effect of seriously limiting the admission rate or length of stay of a person with, say, rheumatic fever, is no control at all. It is, instead, a flat denial to this person of a needed service. The appropriate solution might be to devise an alternative facility or an alternative service.

There are other examples of how data related primarily to the mechanics of payment for hospital care can be used to define health needs in general. Special analyses of the volume of eye operations by age group have been of real value in revitalizing a program to deal with blind cases amenable to surgery and other correction. A detailed tabulation on the incidence of amputations by site proved useful in reconsidering policy on the need for a co-ordinated prosthetic workshop. Hospital care data in quantified form made possible an estimate of likely caseloads should specialized treatment centres be set up for the care of persons with acute or chronic alcoholism. Tabulation of hospitalized cases of multiple sclerosis over an extended period of years served as a valuable method of initial case-finding. An interesting study of recent date is an attempt to discover the postnatal outcome of patients with toxaemia of pregnancy. Hospital care data on all mothers hospitalized with a diagnosis of toxaemia have been matched with birth, stillbirth, and infant death statistics—all of this preliminary to a scientific enquiry into causative factors and their significance.

As a final example: The cost to the province each year of hospitalization for rheumatic fever and rheumatic heart disease was found to approximate $100,000 a year. In a typical year (1956) 470 persons were admitted for rheumatic fever and another 460 for chronic rheumatic heart disease. The hospitalization incidence is known for each public health unit in the province. These data, maintained from year to year, are becoming most valuable, therefore, as case finding and as assessment tools for public health officers currently engaged in programs to stamp out the diseases through penicillin prophylaxis.

Statistical data derived from the operation of a comprehensive hospital care insurance program in Saskatchewan have been used since the inception of the program, in 1947, for administrative control, for co-ordinating efforts in the different planes of health services, and for defining present and future health needs.

These data are useful because, first of all, they are timely and accurate. Second, they are referable to the total population on a province-wide basis, and within discrete geographic regions, and specific social and economic groups. Third, indexes of need, of service experience, and of costs of care can be computed in terms of rates that are valid for comparison. Finally, they are assembled by the policy-making and administering authority and so can be studied for the light they throw on many associated problems in the field of health.

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A-L 12

Here and There . . .

Colour Television to Help in Teaching Surgery

History was made at the Great Hall of the Royal College of Surgeons in London, England, recently when an audience of 500 senior British and French surgeons watched, on colour television, operations being performed at St. Bartholomew's Hospital over a mile away. It was the first closed circuit colour television transmission in British medico-surgical history.

In the above picture the colour television camera is seen trained on an operating table at St. Bartholomew's Hospital during rehearsals.

There are already several closed circuit television installations in British hospitals which project black and white images, but colour is an all-important factor to aid lecturers in medical schools. Colour television is expected to become one of the normal methods of teaching, and the student will be able to see more than he could in the operating theatre.

The British and French surgeons, with other medical men from overseas, were in London to attend the Harvey Tercentenary Congress. The Congress was to commemorate the 300th anniversary of the great English doctor and scientist, William Harvey, who discovered the circulation of the blood—a discovery which marked the beginning of scientific medicine and the end of the superstition that had surrounded the profession from mediaeval times. He was Physician Extraordinary to King James I.—*Courtesy, United Kingdom Information Office.*

Ulster's Five-Year Plan

The last five years are an important landmark in the history of hospital development in Ulster. The £7 million spent on capital development by the Hospitals Authority is considerably more proportionately than has been spent in the rest of the United Kingdom.

Four major projects were initiated during this period—two new hospitals near Londonderry, one at Muckamore, and one at Dundonald on the outskirts of Belfast. Hospital waiting lists began to decline in 1954 and have fallen steadily ever since. Since 1953 more than 1,000 new beds have been added to the 14,000 which were available prior to that date. Specialist services have spread throughout the country, enabling each locality to meet its own needs.

Already at a high pitch of adequacy and efficiency, the public services of Ulster when their program is completed will be second to none.—*Ulster Commentary.*

The Leprosy Problem

Leprosy is a very serious problem in India, where there are about one and one-half million sufferers from the disease. The national authorities have taken large-scale measures, but they need the help of WHO and the other international organizations especially in connection with the new methods of treatment.

In the Philippines, leprosy cases of all types number about 20,000, or, roughly, one per 1000 of the population. Apart from the epidemiological work and domiciliary treatment carried out in liaison with the WHO leprosy control program, the National Leprosy Service has begun to use plastic surgery as a means of rehabilitating patients who have become negative, thus enabling them to resume their normal place in society. A very great educational effort is needed to persuade the mass of the people that there is no justification at all for the social ostracism of lepers.

In Egypt, the law relating to compulsory isolation is no longer applied as a result of the general confidence in the therapeutic value of sulfones. Isolation until the patient is no longer contagious is now optional; when this stage is reached treatment continues through out-patient services. At the present time there are ten central and 40 branch clinics for the diagnosis and treatment of leprosy. Their number is to be increased gradually until all detected cases can be treated.

In French Equatorial Africa, mobile leprosy teams have been operating for the past two years; they treat 100,000 patients.

A campaign along the same lines is being prepared in French West Africa; it was due to commence in 1957 and 300,000 patients were expected to be treated during the first year, rising to 500,000 within a short time. A similar campaign is being prepared in the French Cameroons. In Nigeria, an extensive program for the treatment of 200,000 leprosy patients is in operation; the patients are temporarily isolated and undergo treatment by the permanent or the mobile services. The same thing is being done in Rhodesia. In the Belgian Congo, where 250,000 leprosy cases are being treated, the drugs are administered either orally or by injection.

Leprosy is also regressing in Greece, where a new law authorizes the treatment of patients at home and there is every hope of gradually stamping out the disease.

Thailand intends introducing a five-year plan, the first phase of which will aim at making all leprosy patients in the country non-contagious. According to an approximate estimate, made on the basis of sample surveys, there are 100,000 patients in Thailand.—*Chronicle of WHO.*

Nigeria's New Teaching Centre

The great new University Teaching Hospital at Ibadan, Western Nigeria, which has been formally opened in November, is expected to produce at least fifty doctors every year, as well as a good number of qualified midwives and state-registered nurses. The hospital has been established to serve as a centre of medical education and research and to set up high standards of curative treatment. It will also become the consultant centre for difficult cases.—*WHO Bulletin.*

Provincial Notes
(continued from page 58)

guson, Lindsay, Kaminker, Langley, Keenleyside.

Work is to begin on an $8,000,000 hospital for retarded children near Chatham as part of the provincial program to ease unemployment.

Kirkland and District Hospital has received a contribution of $50,000 towards its new extension from a mining company in the district. The extension is to provide another 31 beds, and increased surgical and kitchen facilities. Architects are Norman Critchley and Lucien Delean of North Bay.

Tenders have been called for a hospital for the Indian Department in Deseronto. Plans call for conversion of the back part of the post office building into a two-storey hospital. On the first floor will be a waiting room, consulting rooms, and a dispensary. On the second floor will be beds for cases of minor surgery and convalescents.

A new $120,000 nursery was opened recently at Mount Hamilton Hospital, the maternity division of Hamilton General Hospitals. The bright new nursery will accommodate 39 infants, each segregated to prevent spread of infection. It is equipped with air conditioning, automatic control of humidity, temperature, and oxygen content of the air, 20 new incubators, and an old repainted rocking chair called "tender loving care."

Work has begun on the two-million dollar addition to St. Joseph's Hospital in Port Arthur. The five-storey extension will provide better services as well as increase the hospital's present 299-bed capacity, since plans include new kitchens, a cafeteria, and renovation of the laundry. Emergency, operating, maternity, paediatric, medical, x-ray, and pathology wards and departments will be extended, and a rehabilitation centre and administration department added. Architects are Fabbro and Townsend, Sudbury.

An indoor ceremony marked the opening of the new wing of Owen Sound General and Marine hospital. The rain did not prevent graduate nurses from providing a guard of honour for those who attended.

Pembroke General Hospital has a new mobile ward x-ray machine, valued at $2,500.

Quebec

Lachute Regional Hospital Board received recently a cheque for $1,000 from the Brownsburg-Lachute Rotary Air Show. A cheque from the Brownsburg C-I-L plant for one-half of the company's $20,000 donation also helped to provide an impetus for the region's hospital building program.

Ste-Rose de Laval Hospital, in Ste-Rose has been officially opened. The 10-bed hospital has one private, one semi-private, and two public wards, as well as a nursery.

The sod has been turned for the new hospital at Magog, near Sherbrooke. Alphonse Belanger of Sherbrooke is architect for the project.

The Kiwanis Nut Campaign meant a $1,200 donation from the St. George Club to Reddy Memorial Hospital, Montreal. This will provide over-bed and bedside tables to complete the furnishings on the third floor.

New Brunswick

Carleton Memorial Hospital, Woodstock, and the Victoria Public Hospital, Fredericton, have each received $2,500 in the will of the late Charles Walter Speirs. Mr. Speirs, a commercial traveller in the area for nearly 50 years, has made bequests to many maritime hospitals and orphanages.

Harvey Station will continue the operation of Harvey Community Hospital as a community project in 1958 when the Red Cross moves out. The vote was unanimous.

A television set was presented to the Provincial Hospital at Campbellton by three Women's Progressive-Conservative Clubs.

Nova Scotia

A second television set has been presented to the Inverness County Hospital at Mulgrave. This set for the men patients was donated by a fisheries company.

A television set was the gift of the ship's company of the RCN ship, Sault Ste. Marie, to the Cape Breton County Hospital, even though none of the crew is a resident of Cape Breton.

Prince Edward Island

Prince County General Hospital has received a donation of $620 from Mrs. Fanny Wetherell of Connecticut for the purchase of an oxygen tent. Mrs. Wetherell's husband died in the hospital, after taking ill while they were on vacation.

The Summerside branch of the Canadian Legion presented Prince County Hospital with a cheque for $1,000. The legion will continue these donations until $100 has been given to the hospital for each of the 103 men from Summerside who gave his life in one of the two world wars or Korea.

Newfoundland

A local business man was so impressed with the efficiency and good spirit he found at Western Memorial Hospital that he has donated $1,000 to this hospital in Cornerbrook.

Twenty Years Ago

The Canadian Hospital
January 1938

The situation in which a number of Toronto hospitals have found themselves as the result of large deficits owing to the heavy cost they have incurred in the treatment of indigent sick, sent to them under city orders, is not a happy one.

These hospitals, although built and equipped very largely by private funds, and their operation directed by voluntary boards, are in the unfortunate position of being obliged to go to the city and plead for funds to meet these deficits.

Most voluntary hospitals in other parts of the province are in a similar position and we feel that the time has come when the vast majority of the public of Ontario are sufficiently well informed upon the splendidly efficient and economical services being rendered to the sick by the hospitals, that they do not desire to see these institutions constantly placed in the financial embarrassment in which they now find themselves.

The Value of Song

Singing lessons for mental patients at the Central Hospital, near Warwick, England, have proved so successful as occupational therapy, that the scheme is to be extended by a grant of £100 from the South Warwickshire Hospital Group Management Committee. Dr. S. W. Gillman, deputy medical superintendent, said that it was introduced as an experiment three months ago, and should be a great help in rehabilitating chronic patients by giving them confidence and fresh interest in life.

Surgeon's elbow . . .

. . . is a prevalent occupational disease in hospitals. It is contracted at most scrub sinks NOT fitted with a Rada *thermostatic* mixing valve. First the user pushes the hot and cold levers and after some juggling gets the temperature just right. Then in the middle of washing someone turns on a tap somewhere with the result that the water suddenly becomes too hot or too cold and the whole frustrating business begins again. Happily preventative measures are available in the shape of the Rada *thermostatic* mixing valve which controls the temperature for you. Choose the temperature you require by a simple movement of the control knob and the Rada does the rest automatically. Radas save time, trouble, fuel and water and make washing or bathing a joy.

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Rates and Benefits

(continued from page 42)

ing the last due date of their premium. As an incentive to enrollment before the commencement of the program, all initial employee subscribers will be credited with three months' insurance protection extending from the date on which the payment of their first premium was made.

A similar period of three months' prepayed insurance is provided for all self-employed individuals if they register and pay the equivalent of one month's premium before October 31, 1958, and the quarterly premium in January 1959.

All persons, whether employees or self-employed individuals, who subsequently enroll will be required to pay or have paid on their behalf a premium appropriate to three months' coverage. In this way all subscribers who maintain regular payments will have three months' prepaid protection. If premiums remain unpaid for three or more months, eligibility for benefits can only be re-established by payment of an amount equivalent to three months' premiums. This action would again restore the subscriber's prepaid position. Any person who falls in arrears on his premium payment will be obliged to pay his own hospital bills unless he is an indigent. The whole financial foundation of the plan depends on faithful adherence to this principle.

Remittances by Firms

All firms with 15 or more employees will be required to register all employees on their payrolls in August 1958. Payments to the Ontario Hospital Services Commission will commence in December 1958. Such firms, and smaller firms who undertake voluntarily to make deductions or payments on behalf of their employees, shall remit to the Commission the amount of the premiums monthly.

Position of Municipalities

As under the new program hospital deficits will be virtually eliminated, many new municipalities that have come to the rescue of these hospitals and assisted them with their deficits will be relieved of this expense. In addition, the province will pay to the municipalities a special unconditional grant to compensate them for the statutory per diem payments that they now make on behalf of the resident indigent patients in the active treatment hospitals and which they will continue to make under the new program.

No hospital insurance program can be operated economically without securing the co-operation of the municipalities in screening indigent cases and enlisting their support to see that indigents are not kept in hospital longer than is necessary. To mobilize their efforts on the side of economy, the municipalities will be required to pay a per diem rate for every resident indigent in active treatment hospitals. In this way, the incentives to economy are harnessed to ensure that indigent patients are not kept for an undue length of time in hospital when lower cost accommodation would adequately meet their needs. The municipalities will, however, enjoy two main advantages over the present system: first, they will be relieved of the payment of hospital deficits; and second, they will receive from the province an additional unconditional grant which will, in general, compensate them for payments made to hospitals on behalf of their indigents. In effect, the province will be relieving the municipalities of an expenditure which in aggregate now amounts to about $12 million per year.

It is very difficult at this time to provide accurate estimates of costs. In recent years, the operating expenditures for the public general hospitals have been rising at a rate in excess of one per cent per month, or about thirteen per cent per year. Part of this cost increase is occasioned by the rise in price of equipment, drugs and other supplies, and of salaries and wages. Part is attributed to the larger population and the much greater care and treatment provided. Costs in 1959 will inevitably be higher than they were in 1957, and in projecting our revenues and premium rates ahead, allowances must be made for these increased costs.

The rates arrived at for the Ontario program are predicated upon Ontario conditions and, of course, its hospital costs. Extensive studies have been made of conditions in other jurisdictions. We have not found that they have had any real relevance to our own particular problem. Comparisons with other provinces are often unrealistic and invalid. Salaries and other incomes, building and material costs, and the need for services all differ. One jurisdiction may finance the cost of its program solely out of taxation; another a part only. Benefits will also differ. Comparisons of premium rates in different jurisdictions, therefore, have little validity.

The total projected cost of the Ontario hospital program, including care and treatment in mental and tuberculosis hospitals in 1959 is about $210 million. Of this amount it is expected that the federal government's contribution will approximate $74 million, or about one-third of the aggregate cost, while the province's contribution will comprise the remainder of $136 million, or nearly two-thirds of the cost. Of the province's share, nearly one-half will come from premiums. It is therefore anticipated that revenues from premiums will total about $75 million, or just over one-third of the cost of the over-all hospital program.

Premium Rates

The premium rates for this comprehensive program will amount to $2.10 per single person, and $4.20 per family per month. The family rate will apply, irrespective of the number of dependent children up to and including 18 years of age. In addition, any unmarried son or daughter who through physical or mental disability is financially dependent on the family, will be considered as a member of the family for hospital insurance purposes. On a quarterly basis, the rates will be $6.30 per single person, and $12.60 per family.

These rates were arrived at after long and careful study, and the results were confirmed by an independent firm of actuaries. The rise in hospital costs is obviously a complicating factor in fixing future rates. A comparison of these rates with those effective today for Blue Cross or any other private carrier would be grossly misleading: first, because the Ontario plan is far more comprehensive in its basic benefits; and second, because the premium rates set out above are predicated on the rise in costs that would inevitably effect the rates of existing carriers by 1959.

If, for instance, Blue Cross were offering its present most comprehensive contract in 1959, its rates for that contract would be $2.10 per individual and $6.60 per family per month. This Blue Cross contract, however, has limitations as to days of stay in hospital and childbirth benefits, and contains other reservations. It does not provide for extended mental and tu-

berculosis care and treatment. If Blue Cross were to attempt to provide the broad benefits of the new Ontario plan, excluding mental and tuberculosis care, its monthly rates would be $3.99 for a single person and $7.98 for a family. With the addition of mental and tuberculosis coverage, these rates would be considerably higher. Similarly, it has been calculated that if the farm co-operative rates for personal premiums were adjusted to provide the comprehensive benefits under the government program, their monthly rates, even without mental and tuberculosis coverage, would be $4.15 for a single person and $8.25 for a family. In comparison with these rates, the premium of $2.10 for a single person and $4.20 for a family under the new Ontario program are indeed favourable.

With the large contributions from the federal and provincial governments, these premiums are at their lowest possible economic level. No private insurance program, operating without such large contributions from general taxation, could provide at these rates such broad and comprehensive benefits. We are confident that the people of Ontario will find the program attractive.

Initially, the program will not provide for out-patient diagnostic services. Careful consideration has been given to this problem, but the difficulty in working out satisfactory arrangements has precluded the adoption of these services at the present time.

The Ontario program will have exclusive occupancy of the basic hospital insurance field. This will mean that other private carriers, including Blue Cross, will be able to concentrate, as never before, on the provision of supplementary health services such as semi-private and private care, medical benefits and sickness indemnity benefits.

Close attention will be paid to methods of maintaining efficiency and economy. The full co-operation of the people and of all agencies having anything to do with admissions services and discharges of patients will be enlisted. In this way a signal advance in the improvement of health services in this province will be made.

Stop thinking about yourself . . . lighten your own load by doing something for someone else . . . it will keep you from morbid worry and fears . . . it's the best medicine. —*Dr. Frederic Loomis.*

Accreditation

(concluded from page 47)

their facilities available for the training program. This is certainly one area that deserves governmental financial support. Hospitals without trained librarians can do much to help their own departments attain a higher standard by sending suitable people for experience to hospitals which have well established records departments. The larger hospitals can be of great assistance in this way.

The advancement of the accreditation program in this province requires much more enthusiasm on the part of our hospitals than has been evident in the past. As pointed out earlier, there is no easy road to accreditation since there is no ceiling on good medical care. But I think you must agree with me that the reward is worth the effort and that the hospital displaying the hall-mark of accreditation is one which can properly merit the respect and confidence of the community it serves.

The Working-together Spirit
(concluded from page 54)

ly when necessity and prudence indicate that he is needed.

To Conclude

In striving for efficiency in techniques and record keeping as in our endeavours to promote better interdepartmental relationships, let none of us lose sight of the great *why* of our activities in the hospital field—whether we be nurses, auxiliary workers, department supervisors, or administrators. The hospital is established for the patient—the patient must be the centre of the picture. We, as a unified group, are here to serve his needs. In the words of Herman Finer, D.Sc., "the purpose of nursing is the unsurpassably excellent care of the patient—this and nothing else is the true focus. Less than this as a sincere standard will not do." It is most important that tremendous confidence be placed in the "team approach", and this team concept is beneficial only if the principles of administration and the relevant understanding of human relations are acquired and applied.

Epilogue

The following day we again find the administrator in his office. He is thinking this time of how his words were received—quite well, apparently, for the discussion was lively, objective, and worthwhile, and even as early as today as he visited the departments he could sense an increased appreciation of the working-together attitude. Thinking of the greatest leader of all time who "came to serve, not to be served", he found himself mentally whispering a prayer: "O God, grant me the serenity to accept the things I cannot change, courage to change the things I should, and wisdom to know the difference!" They say that the wiser we become the more silent we become, he was thinking, but wisdom seemed to him to consist as much in knowing when to speak and when to keep silent. "I myself must always remember that our focus is on the patient, an individual with body, mind, and soul. Morale does not well up from the bottom, it trickles down from the top."

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Her nephew, aged five, was staying with her on holiday. One evening as she passed his door, she overheard him saying his prayers, ". . . and please God make me a good boy, or give my auntie stronger nerves." — *The English Digest.*

You Were Asking . . .

In December the question was *"What commodities and services does your hospital purchase by tender?"*. Several answers not included in last month's issue, for lack of space, are published here. —*Edit.*

Sudbury Memorial Hospital, Sudbury, Ont.

At the present time our hospital calls for tenders on such items as dairy products, bread, and fuel.

It has been our practice to mimeograph a formal quotation sheet on which the specifications of the articles to be purchased are shown clearly. A covering letter, to which the quotation sheet is attached, is forwarded to each of the potential suppliers of these products, and in this letter we usually request the supplier to state his position on price increases, should they occur, and also to state what delivery service they are able to furnish. This letter is sent out under the signature of the purchasing agent, but the supplier is asked, after completing and signing the quotation, to return it to the administrator of the hospital. A re-cap is made of all quotations received, for presentation to the finance committee at their regular monthly meeting. The recommendations of the finance committee are then brought to the regular monthly board meeting for final approval.

We have found that the quotation sheets have had the following advantages: (a) each supplier knows exactly what articles he is expected to quote on; (b) no supplier is given an inkling as to whether his bid is high or low until all bids are received and dealt with by the finance committee; and (c) our purchasing agent is required to set down in writing exactly what he wishes to purchase. He must also include the specifications of the articles to be purchased.

We plan on extending this system to other products and at the present time our purchasing agent is completing a survey of such items to be included in our plan of issuing formal quotation sheets in order to receive competitive bids. I might add that, at no time in the past (nor do we anticipate ever doing so) have we placed an advertisement in our local newspaper for tenders on the various articles. —*H. V. Snyder, Administrator.*

* * *

Miramichi Hospital, Newcastle, N.B.

As this is a small town having (until recently) only one wholesale grocer, one butcher interested in supplying the hospital, one baker, and one dairy, tenders for these items are never requested.

All major equipment, furnishings, repairs and alterations, however, are purchased by tender. We also tender for inspections of elevator and chimney. Drugs, dressings, and routine instruments are purchased from firms with the best prices for the highest quality. These are chosen through using catalogues and after conversations with salesmen rather than by formal tender. — *H. Jean Lynds, Superintendent.*

* * *

Vernon Jubilee Hospital, Vernon, B.C.

For economic operation, to obtain the best price possible and yet gain a good quality product, we find it wise to tender on many of the supplies and services used in the operation of our hospital. However, we find it is not always feasible to call for tenders on some items because the quantity which

will be needed is unknown. In general, I think that fuel should be bought on tender on an annual basis. Tenders for envelopes and quantity forms often bring in surprising results. Certain items of linen might be purchased by the same method, also paper supplies such as paper towels, toilet paper and tray covers.

We use a special "tender form". This is mailed to reputable firms who sell the commodity we are seeking. The amount, quantity, quality, and in some cases the length of supply is stated on this form. The supplier inserts the price, et cetera, he is willing to give, and returns it to the hospital. We do not advertise our tenders in the newspapers (except for construction).

Tenders for these hospital supplies are opened by the administrator who, working closely with the head of the department concerned, makes the final decision. The administrator has standing instructions from the board of trustees to purchase to the best advantage for the hospital. All tenders are filed for review by the board, if necessary. Only for capital items do the board members themselves consider the tenders. —*J. O. Dale, Administrator.*

* * *

Sault Ste. Marie General Hospital, Sault Ste. Marie, Ont.

In this area it is not possible to do any purchasing by tender. A few years ago we could, and did, purchase our coal by tender and it was to our advantage. However, we are now burning sawdust and have no need for coal.

We tried to tender for milk and bread, but both the dairies and bakeries are formed into an association, which means that there is no variation in price. We buy our meat from one firm, because it is the only one that can supply our needs and give us quick delivery.

Our linens are bought wholesale from various firms which give us a good price.

Our insurance is handled by one agency, which distributes it among three other local insurance companies. We get a satisfactory rate, but there is no tendering.—*Sister Teresa Agatha, Administrator.*

The voice of conscience is so delicate that it is easy to stifle it, but it is also so clear that it is impossible to mistake it. — *Mme de Stael, quoted by the English Digest.*

Ghana

(concluded from page 44)

which used to cause periodical devastation in the north, with uncounted deaths and death rates up to 90 per cent, has been tamed so that the most recent epidemics have been accurately reported, and had case mortalities of less than 10 per cent. Confidence in modern medicine has ended any attempt to conceal the disease.

Much remains to be done, and no complacency is felt. But in the 58 years of the Gold Coast's existence, the country has progressed from uncontrolled disease so much that the population has at least doubled itself; nearly everyone has the opportunity to reach a hospital, and the knowledge of where and how to do so; domiciliary midwifery is available to the great majority; and many villages and hamlets are visited by medical field unit teams, surveying and attacking endemic disease, and putting down epidemics.

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M.H.A. Finance Institute
(concluded from page 48)

An interested visitor at the institute was Henry Brickman, Boston, Mass., executive director of the Massachusetts Hospital Association. At the conclusion of the sessions, delegates were the guests of the Maritime Hospital Services Association at a reception and dinner. The guest speaker, R. M. Black, chairman of the Hospital Services Planning Commission of the Province of Nova Scotia, spoke on the federal Hospital Insurance and Diagnostic Services Act.

The institute set a new high for educational programs in the Maritime provinces. This brief review does not begin to indicate the enthusiasm of the registrants nor the high quality of the program itself. Credit is due not only to the director, Walter Dick and his committee of counsellors, but also to Gladys Porter, secretary of the Maritime Hospital Association, who handled registration and other organizational details, to the officers and directors of the Maritime Blue Cross-Blue Shield Plan, and to the administrative personnel of Moncton hospitals.—*M.W.R.*

Looking Inside

(concluded from page 39)

The same holds good with a committee of the co-operatives. They have indicated every desire to work with us in the development and successful working out of the plan. We also met with a committee of the welfare officers appointed by the Ontario Municipal Association, and discussed the effect of the plan on their handling of indigents. We endeavoured to work out with them some common ground on which indigency will be looked after in a standard way in all municipalities. During our discussion with the welfare officers it was found that many hospitals were very dilatory in sending out notice concerning people who were claiming indigency and aid from the municipalities. I mention this matter in an effort to have it corrected.

We also met with representatives of the insurance companies and kept in touch with them as we must have the full co-operation of this group.

Recently we were hosts at a meeting of the provincial ministers of health, deputy ministers and other key officials who were interested in hospital insurance programs. We discussed all the aspects of the Ottawa proposal and agreed to ask for an opportunity to sit down with the federal officials to clarify a number of items about which there was still some uncertainty.

I would here like to bespeak co-operation of the fullest possible extent from the hospital officials of the province. This is not a government plan; it is not a Commission plan; it is a plan for all the people of this province. I think that the hospitals will benefit immeasurably when this plan is in full operation; and administrators, instead of being bothered to death by financial matters, will be able to devote more time to constructive thinking and to the improvement of hospital care for the people.

The 1959 Approach

(continued from page 40)

and a firm of actuaries. The following factors were fully considered before the premium rates were established:

- estimated total provincial population in 1959 and onwards;
- estimated number of hospital beds in 1959 and onwards;
- occupancy rates of hospitals by category of hospital;

- total days of care to be provided by hospital;
- percentage of days of care by public, by private, and by semi-private, and by category of hospital;
- percentage of residents per thousand paying premiums at single and at family rates;
- percentage of population to be covered by premiums and as indigents;
- days of care to be required by non-residents and by Ontario residents hospitalized out of the province;
- increases in hospitals' per diem costs by year, and the relationship of the cost of standard to private and semi-private care;
- the relationship of per diem cost for chronic and convalescent care to active treatment cost.

The actuaries' report of some 54 pages satisfied the Commission that every possible area of cost had been fully considered.

The desirability of introducing the plan with a co-insurance or deductible clause was also debated at length. Those favouring co-insurance argue that a hospital plan should provide only essential services, and partial payments are justified as a device to prevent unnecessary use of services. They feel that partial payments would minimize both unnecessary demands and admissions aimed at obtaining free diagnostic services. Those who are opposed to co-insurance argue that these payments are unfair, deterring only the poor and striking heavily those who need long-term care. Since the plan is set up to enable people to pay for care while they are well rather than when they are in hospital, co-insurance and deductible features, they feel, are a contradiction of the purpose of prepayment. The broad benefits of the announced plan will be paid for in full at cost and without co-insurance, deductible or any other sort of partial payment at the time of hospitalization. Even though every control available to the Commission will be used, this is an open-end contract which can be abused. The Commission cannot regulate which patients shall go to hospital, how long each must stay, nor what services each patient should receive. Everyone concerned with the ultimate cost of the program, including patients as well as hospitals and physicians, shares the responsibility to make sure that fullest use is made

(concluded on page 88)

The 1959 Approach

(concluded from page 87)

of all necessary facilities so that no resident fails to receive adequate care and treatment—and, at the same time, to see that the total cost of the program is kept within reasonable limits. Partial payments, deductibles, or some other form of co-insurance will be inescapable if those concerned fail to use every means to eliminate waste of public funds.

Health care is entering a new era, and not only in the realm of science and medicine. This forward step in prepayment of hospital services, can be of inestimable value both to those engaged in provision of these services and to those who need them. I say "can" be, for it is as certain as tomorrow that only a wholehearted, co-operative effort by everyone will spell success. We are optimistic.

Hospital Facilities

(concluded from page 41)

that recently the Department of Welfare, in co-operation with the municipalities, has developed many fine homes for the aged in which a certain amount of bed care is available. It is believed that these will relieve some of the pressure on hospitals for domiciliary care of the chronically ill. These hospitals will then be freer to devote more facilities to rehabilitation and to active medical treatment of the chronically ill. If more chronically ill can be treated to the point of discharge, this will leave space for some of the patients now in active treatment hospitals who need a long process of rehabilitation without requiring active treatment facilities.

Research

While the Commission, up to the present, has little new to announce in its administration of aid for the development of hospital facilities, it is taking a dynamic interest in the problem. It realizes that while beds represent accommodation for patients, yet many other services, such as modern treatment and diagnostic facilities, are necessary for the best patient care. It is giving very serious study and thought to the problem of what facilities are needed. The returns submitted to us on Form 226 are being tabulated so that we may determine (a) from what geographic area patients come, (b) to what hospitals they go, (c) what illnesses they have, (d) at what ages they come to hospital, (e) how long they stay, and (f) what relation there is between hospital size and illnesses treated. This information on a sampling basis is being placed on tabulating cards so that the relations between any of these factors may be studied.

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Public confidence in hospitals will be weakened unless hospitals meet the challenge of providing adequate facilities for long-term health care.—*Basil O'Connor, president of the National Foundation for Infantile Paralysis, Inc.*

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Teamwork in Action

(concluded from page 52)

very encouraging development. The first in this province was established in Swift Current. The Swift Current Regional Hospital Council, or as it is more correctly titled, The Southwest Regional Hospital Council, now provides its own counselling service in administration, accountancy, dietetics, pharmacy, and medical social work. Two new hospital councils have recently been developed; one at Prince Albert and the other at Wadena, named respectively, the North Central Regional Hospital Council and the Quillplains Regional Hospital Council. So far these councils have not employed any counselling staff, but we expect that in the future, after they have had a little time to analyze their own peculiar needs, they will probably establish a consulting service. The costs of operation of these regional hospital councils is shared on a patient day basis by the participating hospitals. In this way the consultants in the different specialties are actually part-time employees of every hospital in the hospital council area. This gives the hospitals a much better feeling of participation and it makes the consultants' work relatively easier. In addition, they are in a position to give relief service and if their services on a consulting basis are not required to a great extent, to give a proportion of their time to direct service in one of the larger hospitals in the region. This is a pattern which will be watched with considerable interest.

A great deal more can be done to improve standards by this co-operative effort among the hospitals. The improvement in standards of service in the hospitals will greatly develop if their own ability to co-operate is fostered.

Casts in Colour

Patients, especially young ones, are given a choice of pink, yellow, or blue casts at West Jersey Hospital, Camden, N.J. It is all a question of morale, the director of nursing says. The theory is that the old-fashioned white cast lacks "umph" and is dispiriting. Blue is the current favourite.

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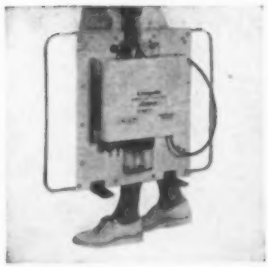

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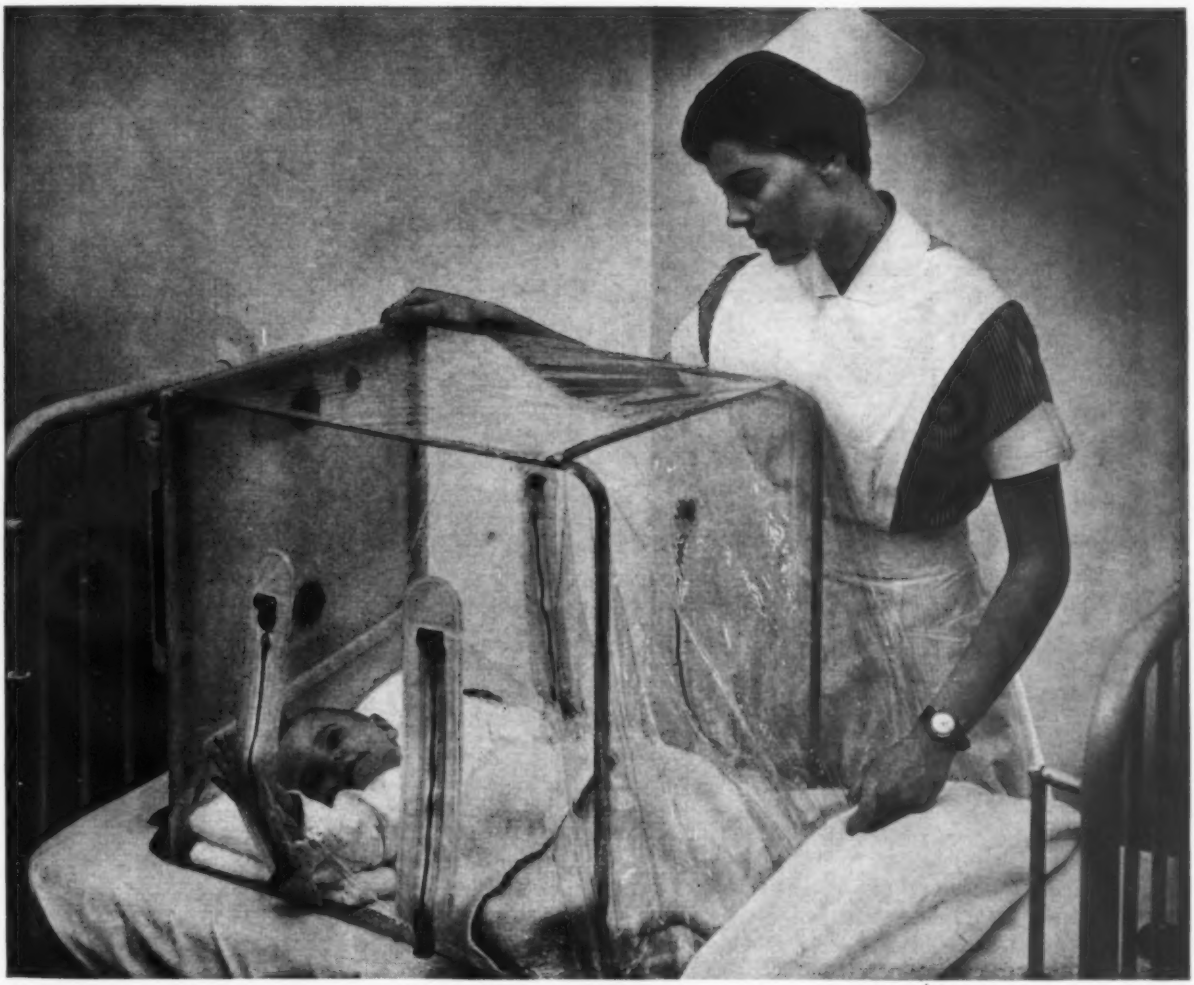

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News Released by Hospital Supply Houses

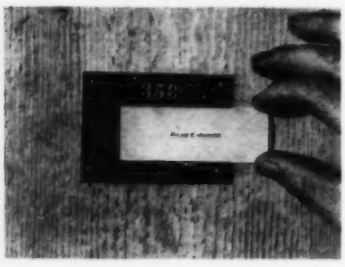
By C.A.E.

New Aluminum Name Plate In Four Colours

A new numbered aluminum name plate with a grooved channel for accommodating a name card has been introduced by J-C Products Corporation, Indianapolis 5, Indiana.

The plate is primarily designed to identify rooms and occupants of institutional buildings, offices and apartments. It is offered in a choice of four anodized colours—black, bronze, brass and natural aluminum, known as Series 1000.

Any sequence of numbers or letters is available. Characters are recessed for permanency and finished in a contrasting enamel—white on the black plate and black on the others. The plate is 3½" wide x 2½". Channel for the name is approximately 1¼" wide.



Full details are shown in Bulletin NP-57, available free from the manufacturer.

Curity Suture Packet Solves Several Problems

A new Curity suture packet designed to solve problems that have harassed surgeons and hospitals for many years has been introduced in Canada. Oddly, perhaps, the packaging of sutures has posed one of the most thorny problems in packaging history, and the new Curity three-layer container marks a milestone.

Up to now, the company states, sutures have been placed in glass tubes and have been hermetically sealed. Thirty-six of these tubes were packed in a glass bottle containing formaldehyde solution to prevent germs living on the outside of the glass tube. When required for use the glass tube was removed from the bottle with forceps and carried to the operating table.

All too often the glass was broken in transit or slipped from the forceps. Glass fragments might cut sterile rubber gloves at a crucial point in the operation, or worse, might even get into an open wound. Yet there seemed no alternative. Glass could be immersed in formaldehyde without any of the solution seeping through to the catgut. It could be hermetically sealed against germs. And it prevented moisture escaping from the catgut itself.

Many attempts have been made to replace glass as a packaging material for sutures but the Curity three-layer packet is the first ever to be entirely successful, it is said, which requires no change in standard hospital routines.

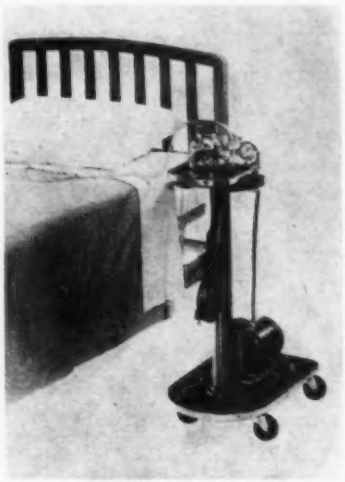
The first layer of the packet is paper, on which the label is imprinted. The middle layer is the most important and is of aluminum foil. It is impervious to moisture and germs alike. The innermost layer is of plastic, which can readily be hermetically sealed.

The new packet can be kept indefinitely in the formaldehyde bottle, just like glass, but it won't crack, chip or break.

New, Mobile, Diaphragm-type Bed-side Compressor-aspirator

A new, mobile bed-side aspirator has been developed by Air-Shields, Inc., maker of the Isolette (R) infant incubator and the Croupette (R) cool-vapor and oxygen tent. This new pump, the Bed-side Dia-Pump, is designed for bed-side or chair-side use in any ward or room where an electrical outlet is available. The Air-Shields Bed-side Dia-Pump provides regulated suction up to 22 inches of mercury, or filtered, oil-free, compressed air up to 30 psi.

The rugged, compact Bed-side Dia-Pump rolls quietly and smoothly on rubber casters; all controls and both gauges are at bed-side height, within easy reach of the nurse. The machine requires a minimum of space, protruding only a foot from the bed or chair. Moreover, the Air-Shields Bed-side Dia-Pump is quiet and virtually trouble-free. On bench test, the pump has been run continuously, day and night, for an entire year, without failure of any part; and the entire unit is unconditionally guaranteed for one year.



The Air-Shields Bed-side Dia-Pump runs without oil, and the motor has only one bearing that needs an occasional drop of oil. The diaphragm seals off the air-line from the pump mechanism, making it impossible for the pump to deliver oil-contaminated air.

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Across the Desk

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Because of the tough neoprene-nylon diaphragm, the pump cannot "freeze," rust, jam or stick from condensed or aspirated moisture.

Full information about the Bed-side Dia-Pump may be obtained from Air-Shields Canada, Limited, 8 Ripley Avenue, Toronto, Ontario.

I.B.M. Time Punch System

An employee inserts time card in the newly announced IBM 8200 Time Punch. Card is punched by the machine to indicate employee attendance data. After punching, the card is fed directly to IBM electric accounting machines for automatic preparation of payroll reports. With conventional time punches, attendance data is merely printed on the card. This printed information must then be translated manually into punched card form to permit automatic accounting. The new Time Punch will save a time clerk many hours a week processing the attendance cards.

I.B.M. Time Punch

Further information available from International Business Machine Company Limited, Don Mills Road, Toronto 6, Ontario.

Catalogues of Laboratory Supplies

Behind Canada's technical achievements in biology and medicine is the vital role played by the laboratory. To equip these laboratories with apparatus, instruments, chemicals and furniture a comprehensive and dependable line of supply is needed. For over a third of a century Canlab has helped maintain this supply-link, offering products of quality, regionally warehoused for prompt delivery from large stocks. Now available are: "The Canlab Show", illustrating the products of leading suppliers; and "Canlab 100', a comprehensive, up-to-date, looseleaf catalogue for the laboratory. Copies available from Canadian Laboratory Supplies, Limited, 3701 Dundas Street West, Toronto 9.

New Mealcart With Automatic Refrigeration

The dining outlook is bright for both the hospital and the menu-minded patient with the recent introduction of the new Shampaine Electric Super Mealcart. Automatic refrigeration keeps cold food cold, and water-proofed heaters in an insulated oven compartment keep hot foods hot. The time

Shampaine Mealcart

of personnel is conserved and patients' tempers cooled, for with the Super Mealcart, food service is quick, efficient and meals are highly appetizing.

An exclusive step-down design (patent pending) provides an unobstructed set-up area at serving counter height for full-size trays, up to 15½" x 20½", just beneath the beverage dispenser.

Consisting of three separate, individual insulated wells, the beverage bar dispenses hot and cold beverages simultaneously. Easy to remove or install, the beverage bar can be used either in combination with the Mealcart or separately for serving "between-meal" liquids.

The Super Mealcart is available in 20-, 24- and 30-meal sizes, with mechanical or cartridge refrigeration, and with or without beverage dispenser. Write to Shampaine Company, 1920 South Jefferson, St. Louis, Mo.

New Baxter Laboratories of Canada Plant is Dedicated

Formal dedication of the new production plant of Baxter Laboratories of Canada, Ltd., was held at Alliston, Ontario, Monday, December 9.

The honoured guest was Dr. C. A. Morrell, director of the Food and Drug Directorate, Department of National Health and Welfare. Dr. Morrell spoke at the dedication dinner following an inspection tour of the new laboratory.

Baxter of Canada, celebrating its 20th anniversary, formerly was located at Acton, Ontario, and moved into its new building in Alliston early last summer.

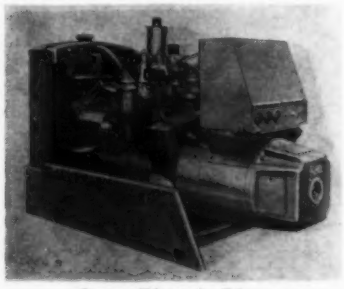
Garland-Blodgett Moves to Larger Quarters

Garland-Blodgett Limited have moved their manufacturing and warehouse facilities to 41 Medulla Avenue, Toronto 14, where they will have greatly increased space.

Specialists in commercial cooking equipment for many years, they also expect to announce shortly many more products for the hospital food preparation department.

Economical Onan 10-15KW Electric Plants

Savings of up to $300 per unit are claimed by D. W. Onan & Sons Inc., Minneapolis, Minnesota, on their new HC series of water-cooled, revolving armature 10 and 15 KW electric plants.



Onan Electric Plant

The new series is available in either 10,000 or 15,000 watt A.C. size ranges in voltages to 460 volts. Completely self-contained, these gasoline engine driven units will provide full-rated electric power for all types of standby emergency applications in hospitals, institutions; wherever there is need for dependable, quick-starting auxiliary power in this capacity.

(concluded on page 97)

Across the Desk

(concluded from page 96)

Prime mover for these new Onan Electric Plants is the heavy-duty, 41 HP, Continental F-162 engine. Direct-connected to an Onan all-climate generator, this rugged 4-cylinder, water-cooled engine operates on either gasoline or gaseous fuel. Standard features include radio suppression, leak-proof water pump, oil bath air cleaner, gear-type oil pump, oil filter with replaceable cartridge, high water temperature cut-off and a 12-volt battery charging generator with the charge rate automatically regulated.

For more complete information and prices on the series HC Electric Plants, write to the manufacturer, D. W. Onan & Sons Inc., 2515 University Avenue S. E., Minneapolis 14, Minnesota.

Barnstead Introduces New Laboratory Sterilizer

The Barnstead Still & Sterilizer Co., Boston, has announced the development of a new hinged-door type of sterilizer with full opening to accommodate large trays and other large items. These units can be supplied in either single or double wall construction. An important new safety feature, supplied as standard equipment in the Barnstead Autoclave, is the built-in device which locks the door handle so it cannot be rotated while there is pressure in the chamber. All models have automatic pressure control.

Standard equipment includes automatic pressure controls, condensation drip shield (on single wall models), dial-type thermometer, chamber pressure guage, jacket pressure guage (on double wall models), pressure safety relief valve, automatic air evacuation, full insulation, stainless steel jackets.

Available in gas, electrically heated, or steam heated models, the Barnstead Autoclave is made of Monel and stainless steel in an all-welded, rivetless construction. For further information, write to Barnstead Still & Sterilizer Co., 171 Lanesville Terrace, Boston 31, Mass.

JAMES H. WILSON

President of the laboratory equipment firm which bears his name, James H. Wilson of Toronto died suddenly in hospital, on November 21, at the age of 69.

Born in Glasgow, Mr. Wilson came to Canada in 1913 and was connected with a number of equipment firms. He established James H. Wilson Limited seven years ago. Mr. Wilson was a member of Ashlar Lodge, AF&AM No. 247, and of Kingsway-Lambton United Church.

New Stryker Catalogue

The Orthopedic Frame Company of Kalamazoo, Michigan, announce the availability of their new catalogue. All Stryker products are illustrated, including the famous Turning Frame, popular Cast Cutter, along with the new Plaster-Vac, Toe Caps and Shower Shields.

Of special interest is the Electro-Surgical Unit to which three new precision built power driven instruments have been aded.

For copies of this new catalogue and complete price lists please communicate with the Canadian agents: Fisher & Burpe Limited, 219 Kennedy Street, Winnipeg 1, Manitoba.

Index of Advertisers

JANUARY, 1958

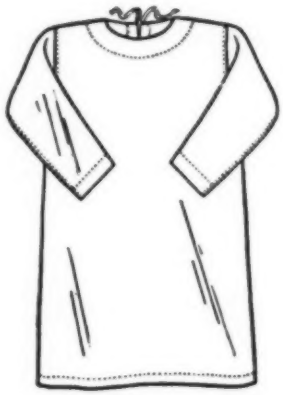
Authorized as Second Class Mail, Post Office Department, Ottawa. The Canadian Hospital is published by The Canadian Hospital Association, 57 Bloor Street West, Toronto 5.

PATIENTS' GOWNS

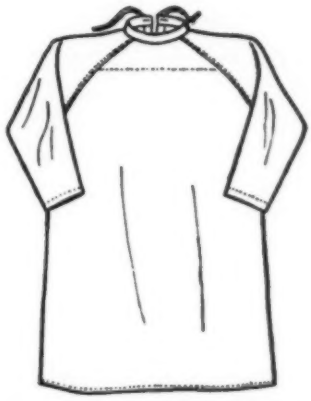
- Materials of the finest quality — "PRE-SHRUNK"
- Cut full and roomy to provide the comfort and ease you wish your patients to enjoy
- Sewn with the very best quality thread obtainable, with all points of strain fully re-inforced
- Back closings with strong, rugged tie taps which permit X Ray without any interference
- Full 40" lengths to comply with standard hospital requirements

PRICED SO MODERATELY

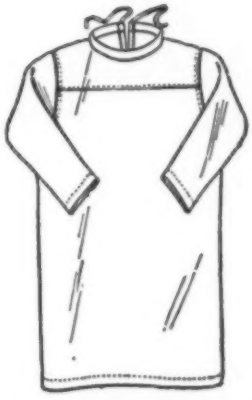
(at no more than the ordinary kind)



No. 404 Patient's Bed Gown



Raglan Sleeve Patient's Gown



No. 407 Patient's Bed Gown

Established 1923

CORBETT-COWLEY LIMITED
C-C SERVICE APPAREL

CORBETT-COWLEY

Limited

2738 Dundas Street W., Toronto 9, Ont. — 424 St. Helene Street, Montreal 1, Quebec

have CLEAN paper towels always handy!

So efficient — They eliminate line up or waiting for someone to finish drying. Economical dispensers can be located wherever convenient.

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So soft — Brompton individual paper towels provide a fast . . . smooth . . . economical drying medium.

So economical — Save money with *low cost* Brompton paper towels.

Brompton K-20—These general service Kraft towels have maximum absorbency and are recommended for general washroom use.

Brompton W-20—These white towels are unsurpassed in quality . . . are lint-free . . . soft . . . very absorbent . . . do not fall apart when wet. They can be used as industrial "white-wipes" to wash, polish or clean up anything.

Made in Canada by St. Lawrence Corporation Limited, Montreal, Que. Mills located at Dolbeau, East Angus and Three Rivers, Que., Nipigon and Red Rock, Ontario.

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